Supreme Court, U.S.
FILED

97 • 218 AUG 4 1997

OFFICE OF THE CLERK

No. 97-

In the

Supreme Court of the United States

October Term, 1996

STEVEN B. LARSEN, IN HIS CAPACITY AS INSURANCE COMMISSIONER OF THE STATE OF MARYLAND,

Petitioner,

v.

AMERICAN MEDICAL SECURITY, INC., *et al.*,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

PETITION FOR A WRIT OF CERTIORARI

J. JOSEPH CURRAN, JR.
Attorney General of Maryland

ANDREW H. BAIDA
Assistant Attorney General
200 St. Paul Place, 20th Floor
Baltimore, Maryland 21202
(410) 576-6318

DENNIS W. CARROLL*
REN L. TUNDERMAN
Assistant Attorneys General
525 St. Paul Place, 2nd Floor
Baltimore, Maryland 21202
(410) 468-2030

*Counsel of Record

Attorneys for Petitioner

87 pp

QUESTION PRESENTED FOR REVIEW

The following question arises out of the State of Maryland's promulgation of a regulation designed to prevent insurers from circumventing State regulatory and consumer laws governing health insurance by offering a health insurance policy under the guise that it is a catastrophic or "stop-loss" policy:

Do the employee benefit pre-emption provisions of the Employee Retirement Income Security Act, 29 U.S.C. § 1144, bar the States from regulating stop-loss insurance policies that State-licensed insurance companies issue to employers to cover health-related claims of employees and their dependents?

PARTIES TO THE PROCEEDING

The parties to the proceeding below were American Medical Security, Incorporated; Client First Brokerage Services, Incorporated; Maran, Incorporated; Trio Metal Products Company, Incorporated; United Wisconsin Life Insurance Company (appellees below); and Dwight K. Bartlett, III, in his capacity as Insurance Commissioner for the State of Maryland (appellant below). Steven B. Larsen has since succeeded Mr. Bartlett as Maryland Insurance Commissioner and is accordingly substituted as a party under Sup. Ct. R. 35.3

TABLE OF CONTENTS

Page

QUESTION PRESENTED FOR REVIEW i

PARTIES TO THE PROCEEDING ii

TABLE OF AUTHORITIES iii

OPINIONS BELOW 1

JURISDICTION 2

STATUTORY AND REGULATORY PROVISIONS INVOLVED 2

STATEMENT OF THE CASE 2

REASONS FOR GRANTING THE WRIT 8

I. THIS CASE INVOLVES AN IMPORTANT QUESTION CALLING FOR THIS COURT'S INTERVENTION: WHETHER THE STATES CAN CONTINUE TO REGULATE A SIGNIFICANT AND EXPANDING PORTION OF THE INSURANCE INDUSTRY 8

II. THE DECISION BELOW CONFLICTS WITH THIS COURT'S ERISA DECISIONS 11

III. THE DECISION BELOW CONFLICTS WITH DECISIONS OF OTHER COURTS OF APPEALS 16

CONCLUSION 19

TABLE OF AUTHORITIES

Page

CASES:

Brown v. Granatelli, 897 F.2d 1351 (5th Cir.), *cert. denied*, 498 U.S. 848 (1990) 16,18
DeBuono v. NYSA-ILA Medical and Clinical Services Fund, 117 S.Ct. 1747 (1997) 11
FMC Corp. v. Holliday, 498 U.S. 52 (1990) . . . 13-15,17
Lincoln Mutual Casualty Company v. Lectron, 970 F.2d 206 (6th Cir.1992) 17
Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) 8, 11-14,16
Michigan United Food and Commercial Workers Unions v. Baerwaldt, 767 F.2d 308 (6th Cir.1985), *cert. denied*, 474 U.S. 1059 (1986) 16,17,18
Moore v. Provident Life and Accident Ins. Co., 786 F.2d 922 (9th Cir.1986) 18
New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S.Ct. 1671 (1995) 11,14
Northern Group Services, Inc. v. Auto Owners Insurance Company, 833 F.2d 85 (6th Cir.1987), *cert. denied*, 486 U.S. 1017 (1988) 7,16,17,18
Thompson v. Talquin Bldg. Products Co., 928 F.2d 649 (4th Cir.1991) 7,18
United Food and Commercial Workers v. Pacyga, 801 F.2d 1157 (9th Cir.1986) 18

STATUTES, RULES AND REGULATIONS:

28 U.S.C.
§ 1254(1) 2
§ 1331 7
29 U.S.C.
§ 1132(a)(3) 7
§ 1144 6

§ 1144(a) 2,7,12
§ 1144(b)(2)(A) 2,7,12
§ 1144(b)(2)(B) 2,7,12
Md. Ann. Code Art. 48A, § 375 5,6
Alaska Stat. § 21.12.050 (1997) 10
Colo. Rev. Stat. § 10-16-119 (1995) 9
Fla. Stat. Ann. § 627.6482 10
215 Ill. Comp. Stat. 5/353 and 5/4 (1996) 10
Me. Rev. Stat. Ann., Tit. 24A, § 707(1)(c-1) (1994) 9
Mich. Bulletin 94-09 10
Minn. Stat. § 60A.235 (1995) 9
Mo. Code Regs. Title 20, § 400-2.150 (1995) 9
N.H. Insurance Regulation § 401.01(e)(3) 10
N.C. Gen. Stat. § 68-50-130(5) 10
27 N.J. Reg. 4320 9
Or. Rev. Stat. § 742.065 (1995) 9
Va. Administrative Letter 1980-7 10
Wash. Rev. Code § 48.21.015 (1995) 9
Supreme Court Rules
13.3 2
35.3 ii
Code of Maryland Regulations
§ 09.31.02 2

MISCELLANEOUS:

Employer-Based Health Plans: Issues, Trends, and Challenges Posed by Erisa, United States General Accounting Office, GAO/HEHS-95-167 9,15
Lenhart, ERISA Preemption: The Effect of Stop-Loss Insurance On Self-Insured Health Plans, 14 Va. Tax. Rev. 615 (1995) 19
Paredes, T., *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 Harv. J. on Legis. 233 (1997) . . 9,19

No. 97-__

In the

Supreme Court of the United States

October Term, 1996

STEVEN B. LARSEN, IN HIS CAPACITY AS INSURANCE COMMISSIONER OF THE STATE OF MARYLAND,

Petitioner,

v.

AMERICAN MEDICAL SECURITY, INC., *et al.*,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

PETITION FOR A WRIT OF CERTIORARI

The Maryland Insurance Commissioner respectfully petitions this Court for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit.

OPINIONS BELOW

The April 11, 1997 opinion of the United States Court of Appeals for the Fourth Circuit is reported at 111 F.3d 358 and is reproduced in the Appendix ("App.") at 1a-15a. The court of appeals' May 6, 1997 order denying petitioner's request for rehearing and suggestion for rehearing in banc is unreported and is reproduced at App. 16a-18a. The February 23, 1996 opinion of the United

States District Court for the District of Maryland is reported at 915 F.Supp 740 and is reproduced at App. 19a-37a.

JURISDICTION

The court of appeals' opinion and judgment were entered on April 11, 1997. The order denying petitioner's timely filed petition for rehearing and suggestion for rehearing in banc was entered on May 6, 1997. This petition is filed within 90 days of that order pursuant to Sup.Ct.R. 13.3. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

This case involves the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1144(a), 1144(b)(2)(A), and 1144(b)(2)(B), and a regulation of the Maryland Insurance Commissioner, Code of Maryland Regulations, § 09.31.02. The text of these provisions are reproduced at App. 58a-62a.

STATEMENT OF THE CASE

This petition seeks review of a judgment of the United States Court of Appeals for the Fourth Circuit, which holds that ERISA pre-empts the State of Maryland from regulating stop-loss insurance policies that insurance companies sell to employers to cover health-related claims made by their employees and families.

A stop-loss insurance policy is a policy that an otherwise self-insured benefit plan purchases to insure an employer, which provides health insurance coverage to its employees, against catastrophic or unexpected losses. App. 40a. Stop-loss insurance policies contain "attachment points" above which the insurer reimburses the employer for claims paid. Payment of claims below the attachment

point is the responsibility of the employer and represents the level of self-insurance, or risk, that the employer retains. *Id.* Stop-loss policies typically have specific and aggregate attachment points. A policy with a specific attachment point provides that the employer is solely responsible for all claims filed on behalf of each employee up to a fixed dollar amount, and that the insurer's liability attaches for the employee's claims in excess of that attachment point. A policy with an aggregate attachment point provides that the insurer's liability attaches at a fixed percentage of expected claims for all employees.

There is no dispute that while the States may not regulate a self-funded ERISA plan's health-related benefits, ERISA nonetheless permits the States to regulate insurance policies that ERISA plans purchase to provide health benefits to employees. As the Maryland Insurance Commissioner stated, the law at issue in this case was prompted by the concern that stop-loss policies with very low attachment points constitute the equivalent of purchased health insurance and an effort by employers to evade Maryland's regulatory laws:

> The effect of having a low attachment point is that the insurance carrier issuing the "stop loss" coverage is, in reality, providing direct health insurance. The attachment point is merely a deductible. . . .When insurers undertake the subterfuge of categorizing an employer as self-insured, and thus exempt from the state's laws, yet provide an unapproved insurance product which acts as a replacement for direct insurance, consumers are denied the protections and benefits intended by the Maryland General Assembly.

App. 41a-42a.

Prior to promulgating the regulation that triggered this

litigation, the Maryland Insurance Commissioner had regulated stop-loss insurance and the appropriate attachment points for over twenty years. App. 40a. Minimum attachment points had been enforced as a matter of agency policy. Following the Maryland General Assembly's passage of significant health care reform in 1993, the Insurance Commissioner received complaints that stop-loss policies were being marketed with attachment points as low as $500 or $1,000. App. 41a. To respond to the complaints and the concern that insurance carriers were selling policies that did not comply with State law consumer protection provisions, the Commissioner proposed a regulation that established a specific minimum attachment point of $20,000 and an aggregate attachment point of 125% of expected claims. App. 38a. Policies with lower attachment points would be considered health insurance policies under State law and thus be subject to the provisions of the State insurance code. App. 40a; 55a.

As part of his regulatory review, the Maryland Insurance Commissioner in November of 1995 held a public hearing to receive testimony from affected citizens, including employers, insurers and the employee benefit industry, on the attachment points set forth in the proposed regulation. As set forth in an Order that the Commissioner subsequently issued in adopting this regulation, "[t]he vast majority of all witnesses and commentators have expressed the view that some attachment point is appropriate. Nearly everyone agrees that at 'low' attachment points, the policy in reality becomes a health insurance policy and not merely a catastrophic loss policy." App. 46a.

The Commissioner noted further that a representative of American Medical Security, a party in this case, testified that a "specific attachment point of $500 is 'abusive', that $2000 is 'absurd', that some regulation is necessary, and that a specific attachment point in the $5,000-10,000 range

is reasonable." App. 46a n.3. The Commissioner also concluded that the use of low attachment points "results in unfair competition in the insurance market" because it enables "companies selling unapproved stop loss policies" to "undercut" the efforts of insurers selling "approved products," who "spend a great deal of time and money to develop new products to comply with term and rate filing requirements and to remain competitive in light of the long list of Maryland mandated benefits." App. 41a.

Following the public hearings, the Commissioner adopted a modified stop-loss regulation that set a specific attachment point of $10,000. App. 56a-59a. The regulation does not apply to an employee benefit plan but rather explicitly applies to policies or contracts of insurance issued or renewed by insurance carriers and nonprofit health services plans. App. 56a-57a.

Maryland's regulation provides that a policy with an attachment point of at least $10,000 will be treated as a stop-loss health insurance policy that the Commissioner will approve. App. 58a. If the policy includes an attachment point that is below the regulatory minimum, however, the Commissioner will not approve it as a stop-loss policy but will instead consider it to be a health insurance policy, approvable only if it meets the State law requirements for health insurance. App. 57a-58a.[1] These requirements include, among other things, mandated benefits. App. 40a.

In late 1994, the Insurance Commissioner learned that one of the plaintiffs in this action, United Wisconsin Life Insurance Company, had been selling unapproved insurance policies to Maryland employers with specific attachment

---

[1] No insurer may sell any insurance policy unless the policy is filed with and approved by the Commissioner. *See* Md. Ann. Code Art. 48A, § 375.

points as low as $2,500 and $3,000, well below the regulatory minimum. App. 23a. The Commissioner directed United Wisconsin, as a licensed insurer in the State of Maryland, to cease issuing stop-loss insurance policies that were not approved. J.A. 55-57.[2] The Commissioner issued a similar directive to another plaintiff, American Medical Security, which operated in conjunction with United Wisconsin, forbidding its sale of unapproved stop-loss insurance policies. J.A. 52-54. Both parties were informed that, under Maryland law, insurance contracts sold in the State must be filed with and approved by the Maryland Insurance Administration.

A licensed insurer's failure to obtain approval before selling an insurance contract could result in sanctions against the insurer in accordance with the Maryland Insurance Code. *See* Md. Ann. Code Art. 48A, § 375. No similar provision applies to employee benefit plans, however, and the Commissioner did not issue any order, request or demand of any kind to any employee benefit plan. No threat of sanctions or enforcement was made against any plan.

After being instructed to cease selling unapproved stop-loss policies, United Wisconsin, American Medical Security, and three small employers filed a complaint in the United States District Court for the District of Maryland seeking an injunction against the Commissioner's regulation, claiming that ERISA, 29 U.S.C. § 1144, pre-empts the Commissioner from regulating attachment points in stop-loss insurance policies. App. 20a. Jurisdiction was

---

[2] References to "J.A." are to the Joint Appendix filed in this case in the court of appeals.

based on 28 U.S.C. § 1331 and ERISA, 29 U.S.C. § 1132(a)(3).

After the parties filed cross-motions for summary judgment, the district court entered judgment for the plaintiffs. The court first found that the regulation of attachment points "relates to" ERISA plans and, therefore, falls under ERISA's general pre-emption provision set forth in 29 U.S.C. § 1144(a). App. 27a. The court next determined that the regulation of attachment points "regulates insurance" within the meaning of 29 U.S.C. § 1144(b)(2)(A), since the "regulation 'directly controls the terms of insurance contracts' by mandating, *inter alia*, minimum attachment points in order for a policy to be considered stop loss insurance." App. 29a. While this type of regulation typically is not pre-empted under ERISA's insurance saving clause, the court nonetheless found that Maryland's stop-loss regulation "deems" ERISA plans to be insurers as set forth in 29 U.S.C. § 1144(b)(2)(B). App. 28a-33a. The district court accordingly held that the regulation of stop-loss attachment points is pre-empted under ERISA, and enjoined the Insurance Commissioner from regulating stop-loss insurance policies. *Id.*

The court of appeals affirmed. The court acknowledged that "plans that provide benefits in the form of insurance may be indirectly regulated through regulation of that insurance. . . ." App. 6a. The court then cited, *inter alia*, *Thompson v. Talquin Bldg. Products Co.*, 928 F.2d 649, 653 (4th Cir.1991), which explicitly rejected *Northern Group Services, Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir.1987), in holding that ERISA pre-empts the application of State law to an employee benefit plan that purchases stop-loss insurance. Relying on *Thompson*, the court below stated that "plans that are self-funded or self-insured may not themselves be regulated as insurance companies even if the self-funded or self-insured plan

purchases stop-loss insurance to cover losses or benefits payments beyond a specified level." App. 6a-7a. The court thus affirmed the judgment of the district court, finding that "[e]ven though the regulatory language targets stop-loss insurance policies," the regulations violate ERISA because they "require self-funded plans to offer coverage consistent with state insurance law. . . ." App. 12a. The court of appeals subsequently denied Maryland's petition for rehearing and suggestion for rehearing in banc. App. 16a.

REASONS FOR GRANTING THE WRIT

This case presents the important question whether the States are barred from regulating a common form of insurance whose increasing popularity and misuse are having a substantial and adverse effect on millions of employees. Certiorari is warranted because the court of appeals resolved that question in a way that directly conflicts with this Court's holding in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), that the States *can* regulate insurance that is purchased by ERISA plans, and with decisions of the court of appeals for the Sixth Circuit upholding the States' right to regulate stop-loss insurance.

I. THIS CASE INVOLVES AN IMPORTANT QUESTION CALLING FOR THIS COURT'S INTERVENTION: WHETHER THE STATES CAN CONTINUE TO REGULATE A SIGNIFICANT AND EXPANDING PORTION OF THE INSURANCE INDUSTRY.

The use of stop-loss insurance as an ERISA plan funding device is growing and affects countless working citizens throughout the country. The United States General Accounting Office estimated in a recent report that approximately 114 million individuals representing 44 percent of the U.S. population are covered by ERISA health

plans, and that nearly 40 percent of these plans, covering about 44 million people, are funded at least in part by the employer. *See Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA*, GAO-HEHS-95-167, July 1995, at 2-3. Moreover, as one commentator noted, "[t]he most recent data show that over 70% of otherwise self-funded plans are covered by some form of stop-loss insurance," and "that number is increasing." Paredes, T., *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 Harv. J. on Legis. 233, 235 (1997).

State insurance commissioners across the nation are currently regulating stop-loss insurance policies -- many by adopting minimum attachment points -- in response to concerns about the impact of their use.[3] Those concerns are

---

[3] Maryland's regulation of stop-loss insurance policies is similar to regulatory action that a number of other States have implemented. *See* COLO. REV. STAT. § 10-16-119 (1995) (specific attachment point ("SAP") $10,000, aggregate attachment point ("AAP") 120%); CT Bulletin PC-7-90 (SAP $6,500); KS Bulletin 1993-12 and 1997-7 (SAP $10,000, AAP 125%); ME. REV. STAT. ANN., Tit. 24A, § 707(1)(c-1) (1994) and June 5, 1992 Guideline (SAP $10,000, AAP 120%); MINN. STAT. § 60A.235 (1995) (SAP) $10,000, AAP variable); MO. CODE REGS. tit. 20, § 400-2.150 (1995) (SAP $10,000, AAP 120%); 27 N.J. REG. 4320 (SAP $25,000, AAP 125%); OK Bulletin March 20, 1991 (SAP $7,500, AAP 120%); OR. REV. STAT. § 742.065 (1995) (SAP $10,000); TN Bulletin October 18, 1995 (SAP $10,000, AAP 120%); WASH. REV. CODE § 48.21.015 (1995) (SAP 5%/$100,000, AAP 120%). Several States also regulate stop-loss insurance by requiring forms to be filed and approved, and by imposing on insurance carriers that offer stop-loss insurance a number of requirements affecting their

(continued...)

that an expanding number of insurers are offering stop-loss insurance to enable employers to create the subterfuge that their health plans are self-funded. Once the self-funded label is attached to an ERISA plan, the plan is exempt from the States' laws regulating traditional health insurance, even though the employer hides behind the plan to transfer the bulk of its risk to an insurance carrier rather than hold the risk itself. The plan's "self-funding" is minimal, and the insurance package it purchases is a great deal more than a stop-loss package. Indeed, as the Maryland Insurance Commissioner found, "[t]he effect of having a low attachment point is that the insurance carrier issuing the 'stop loss' coverage is, in reality, providing direct health insurance" with the attachment point representing "merely a deductible" for the employer. App. 41a. The end result of this arrangement is an insurance package that "avoids all mandates and all consumer protections." *Id.*

In holding that Maryland has been pre-empted under ERISA from regulating stop-loss insurance policies that insurance companies sell to allegedly self-insured

---

(...continued)
licensing status, the reserves they must keep and their guarantee fund responsibilities, and the mandated benefits they offer. *See* ALASKA STAT. § 21.12.050 (1997); FLA. STAT. ANN. § 627.6482; 215 ILL. COMP. STAT. 5/353 and 5/4 (1996); MICH. Bulletin 94-09; NH Insurance Regulation § 401.01(e)(3); N.C. GEN. STAT. § 68-50-130(5); and VA Administrative Letter 1980-7. In recognition of the national implications of this case, the National Association of Insurance Commissioners ("NAIC"), which is an association of the principal insurance regulators of the fifty States, the District of Columbia, and the four United States territories, filed an amicus brief in support of the Maryland Insurance Commissioner in the court of appeals below.

employers, the court of appeals has fashioned a rule that strips the States of any ability to enforce legitimate and important health insurance requirements, and precludes the States from prohibiting even sham arrangements in the health insurance industry. Congress did not intend ERISA to prevent the States from addressing a matter of such historical local concern, nor did it mean to allow an employer to seek shelter under federal law from general health care regulation when, as in the situation addressed by the laws of Maryland and many other States, the employer uses stop-loss insurance to cover the health-related claims of its employees and their dependents.

II. THE DECISION BELOW CONFLICTS WITH THIS COURT'S ERISA DECISIONS.

In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), this Court held that ERISA does not pre-empt the States' regulation of insurance policies providing health coverage that insurance companies sell to ERISA plans or employers. The court of appeals' decision prohibiting Maryland's regulation of stop-loss insurance directly conflicts with *Metropolitan Life* because stop-loss insurance is insurance that a carrier sells to employers to cover employees' health claims. The court of appeals compounded its error by disregarding this Court's repeated admonishment that proponents of ERISA pre-emption "bear the considerable burden of overcoming 'the starting presumption that Congress does not intend to supplant state law.'" *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 117 S.Ct. 1747, 1752 (1997) (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S.Ct. 1671, 1676 (1995)).

The law at issue in *Metropolitan Life* required the inclusion of minimum mental health-care benefits in insurance policies that ERISA employee benefit plans

purchased. The Court initially found that Massachusetts's law "relate[s] to" a benefit plan and so fell within the reach of the pre-emption provision set forth in 29 U.S.C. § 1144(a), which provides that, "[e]xcept as provided in subsection (b) of this section," the ERISA statute "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." The Court nevertheless held that the State's law was exempted from § 1144(a) by the "saving clause" set forth in § 1144(b)(2)(A), which preserves any State law that "regulates insurance, banking, or securities." Stating that the Court "must presume that Congress did not intend to pre-empt areas of traditional state regulation," 471 U.S. at 740, the Court applied the plain language of the saving clause and held that Massachusetts's law was not pre-empted because it "regulates the terms of insurance contracts, and so seems saved from pre-emption by the saving clause as a law 'which regulates insurance.'" *Id.*

Maryland's law similarly falls within the scope of the saving clause because, as the court of appeals in this case recognized, Maryland's "regulations are carefully drafted to focus directly on insurance companies issuing stop-loss insurance and not on the employee benefit plans themselves." App. 11a. The court found, however, that because the regulations' "purpose and effect are directed at self-funded employee benefit plans that attempt to provide fewer health benefits to Maryland residents than state law mandates for health insurance policies," *id.*, "Maryland's law violates the ERISA provision that no ERISA plan 'shall be deemed to be an insurance company . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts.'" App. 12a (quoting 29 U.S.C. § 1144(b)(2)(B)). The court of appeals fundamentally misinterpreted ERISA in a way that cannot be reconciled with *Metropolitan Life*.

The "deemer clause" that the court relied upon in finding that Maryland's law is pre-empted actually reinforces the opposite conclusion. That clause provides that an employee benefit plan shall not be deemed to be an insurance company "for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." As this Court stated in *Metropolitan Life*, "[b]y exempting from the saving clause laws regulating insurance contracts that apply directly to benefit plans, the deemer clause makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause." 471 U.S. at 741. The court of appeals thus misapplied the deemer clause, because that clause "makes clear that if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts. . . ." *FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990).

As a result of this error, the lower court ignored the crucial distinction between the direct application of a State law to an insurer, which ERISA permits, and the direct application of the same law to an employee benefit plan, which federal law prohibits. *See Metropolitan Life*, 471 U.S. at 735 n.14 and 746-47; *FMC Corp.*, 498 U.S. at 62. ERISA does not pre-empt a State law that regulates insurance contracts merely because, as the court of appeals found to be the situation here, the State law has an indirect effect on employee benefit plans when it uses "insurance policies as a vehicle to impose the requirements of . . . health insurance law" on those plans. App. 12a. On the contrary, this Court in *Metropolitan Life* made clear that an employee benefit plan that purchases insurance to cover the health-related claims of its employees is *not* exempt from the States' historic right to regulate insurance contracts,

even when a State's law "bears indirectly but substantially on all insured benefit plans" by "requir[ing] them to purchase . . . benefits specified in the statute when they purchase a certain kind of common insurance policy." 471 U.S. at 740. *See also New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S.Ct. at 1680 ("[L]aws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those 'conflicting directives' from which Congress meant to insulate ERISA plans."). The court of appeals was wrong in finding otherwise, therefore, because "employee benefit plans that are insured are subject to indirect state insurance regulation." *FMC Corp. v. Holliday*, 498 U.S. at 61.

The court of appeals' misapplication of these principles is attributable to its mistaken belief that an ERISA plan affected by Maryland's law is "self-funded" or "self-insured" -- and thus exempt from regulation under the deemer clause -- even when the "plan purchases stop-loss insurance to cover losses or benefits payments beyond a specified level." App. 7a. As this Court has recognized, however, "nothing in [the saving clause], or in the 'deemer clause' which modifies it, purports to distinguish between traditional and innovative insurance laws." *Metropolitan Life*, 471 U.S. at 741. Maryland has the right to regulate stop-loss insurance because "[a]n insurance company that insures a plan remains an insurer for purposes of state laws 'purporting to regulate insurance' after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation." *FMC v. Holliday*, 498 U.S. at 61. In these circumstances, "[t]he ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer." *Id.*

It is undisputed in this case that, as the court of appeals repeatedly found, Maryland's law on its face applies only

to insurers. *See, e.g.*, App. 10a-11a ("The regulations, by their own terms, seek to impose requirements only on insurance companies and their stop-loss insurance policies."). It is also undisputed that the Maryland Insurance Commissioner has taken no action to enforce the State's law against anyone other than the insurer, and that no employer or employee benefit plan has been required or even asked to do anything with respect to Maryland's law. The Commissioner is simply not regulating ERISA plans in any fashion, but is instead regulating an insurance company in the sale of insurance. ERISA does not pre-empt such traditional State regulatory activity; rather, the explicit language of "the saving clause retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans." *FMC v. Holliday*, 498 U.S. at 64.

In incorrectly applying ERISA, the court of appeals has erected a rule that deprives the States of any authority to regulate an increasingly used insurance device that more and more States have sought to regulate because of its high potential for abuse. *See also Employer-Based Health Plans: Issues, Trends, and Challenges Posed by Erisa*, United States General Accounting Office, GAO/HEHS-95-167, at 16 (to address "new stop-loss insurance products that . . . allow small firms to self-fund, avoiding state regulation, while only bearing a small portion of the risk. . ., the National Association of Insurance Commissioners (NAIC) is developing a model act that would define minimum stop-loss coverage levels, preventing the sale of products that are merely a subterfuge for traditional health insurance."). State regulatory bodies must have the ability, however, to "look beyond form to the substance of the relationship between the plan, the participants, and the insurance carrier to see whether the plan is in fact purchasing insurance for itself and not for the plan

participants, recognizing that as insurance is less for catastrophic loss, it is increasingly like accident and sickness insurance for plan participants." *Brown v. Granatelli*, 897 F.2d 1351, 1355 (5th Cir.), *cert. denied*, 498 U.S. 848 (1990).

Applying that scrutiny to stop-loss policies issued in Maryland, the State's Insurance Commissioner found that a stop-loss insurance policy with a low attachment point is the equivalent of a health insurance policy with a deductible and, therefore, must provide the protections and benefits mandated by Maryland law. App. 41a. Congress did not intend to prohibit the States from exercising their right to regulate insurance in circumstances such as these and to determine the substantive terms of insurance contracts that licensed insurers sell.

III. THE DECISION BELOW CONFLICTS WITH DECISIONS OF OTHER COURTS OF APPEALS.

Review is also warranted because the court of appeals' decision conflicts with decisions of other federal appellate courts. In *Michigan United Food and Commercial Workers Unions v. Baerwaldt*, 767 F.2d 308 (6th Cir.1985), *cert. denied*, 474 U.S. 1059 (1986), the court of appeals held that ERISA does not pre-empt the application of a State mandated-benefit statute to stop-loss policies that insurance companies sold to otherwise self-funded ERISA plans. Finding this Court's decision in *Metropolitan Life* to be controlling, the court of appeals stated that "[t]he stop-loss nature of the plans does not alter our conclusion," 767 F.2d at 312, and concluded that "[a]s long as the plans purchase insurance from 'an insurer offering health insurance policies in' Michigan, the policies must include the substance abuse coverage specified by [Michigan law]." *Id.* at 313.

In *Northern Group Services, Inc. v. Auto Owners*

Insurance Company, 833 F.2d 85 (6th Cir.1987), *cert. denied*, 486 U.S. 1017 (1988), the court of appeals reaffirmed this holding in finding that ERISA did not pre-empt the application of a Michigan coordination-of-benefit statute to an ERISA plan that was covered by stop-loss insurance. Stating that "direct regulation of the content of insurance policies that an ERISA plan purchases is not barred by the deemer clause," 833 F.2d at 90, the court rejected the plan administrator's argument that the plan was "self-insured" and thus exempt from Michigan's law. Rather, the court held "[t]hat the Plan pays a deductible does not alter the fact that benefits payable above specified levels, either on an individual beneficiary or in the aggregate, are nonetheless insured." *Id.* at 91. Accordingly, the court held that State law as applied to the stop-loss insurer was not pre-empted.[4]

Neither of these decisions can be reconciled with the decision of the court of appeals below. The Michigan law at issue in *Michigan United Food* was much more sweeping in its scope than the law that the court of appeals invalidated in this case: Maryland's law imposes mandated benefits only on those stop-loss policies that have been determined to be, in reality, health insurance policies, while Michigan's law imposed the mandated-benefit requirement

---

[4] The court also held that ERISA did not pre-empt the application of Michigan's law to three plans that were "totally self-insured." 833 F.2d at 91. This portion of the court's decision was later overruled in *Lincoln Mutual Casualty Company v. Lectron*, 970 F.2d 206, 210 n.3 (6th Cir.1992), as "no longer viable" in light of this Court's intervening decision in *FMC v. Holliday*, 498 U.S. 52 (1990), which "read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause." *Id.* at 61.

on *all* stop-loss insurance policies. Thus, the Maryland law that the court of appeals below struck down would certainly be upheld by the Sixth Circuit.

Rather than attempt to reconcile its views with either *Michigan United Food* or *Northern Group*, the court of appeals for the Fourth Circuit has explicitly rejected those decisions. Indeed, in stating that a plan's purchase of stop-loss insurance does not save a State's insurance law from pre-emption, App. 6a-7a, the court of appeals below cited its earlier decision in *Thompson v. Talquin Bldg. Products Co.*, 928 F.2d 649 (4th Cir.1991), in which the court there noted -- and then refused to follow -- *Northern Group* and held instead that the purchase of "stop-loss insurance does not convert [an employer's] self-funded employee benefit plan into an insured plan." 928 F.2d at 653. In reaching this decision, the court in *Thompson* rejected the contrary holding of the court of appeals for the Sixth Circuit in favor of the Ninth Circuit's "persuasive" reasoning in *Moore v. Provident Life and Accident Ins. Co.*, 786 F.2d 922 (9th Cir.1986), and *United Food and Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir.1986), in which the court of appeals in those cases found that an ERISA plan that purchases stop-loss insurance constitutes an uninsured plan covered by the deemer clause.[5]

As one commentator recently noted, "[t]he current confusion and disagreement among the circuit and district courts have caused uncertainty for state regulators, employers and their plans, plan participants, and courts,

---

[5] Noting this conflict between the decisions of the courts of appeals for the Sixth and Ninth Circuits, Judge Brown in his dissenting opinion in *Brown v. Granatelli*, 897 F.2d 1351, 1357 n.5 (5th Cir.), *cert. denied*, 498 U.S. 848 (1990), stated that "the better reasoned approach is that adopted by the Sixth Circuit...."

especially those courts that have not yet considered the issue of stop-loss insurance." Paredes, *Stop Loss Insurance, State Regulation and ERISA: Defining the Scope of Federal Preemption*, 34 Harv. J. on Legis. at 258. *See also* Lenhart, *ERISA Preemption: The Effect of Stop-Loss Insurance On Self-Insured Health Plans*, 14 Va. Tax. Rev. 615, 616 (1995) ("Despite the prevalence of such health coverage. . . regulation of such plans remains hopelessly muddled."). Moreover, the explosive growth of stop-loss insurance as a means of covering employee claims has significantly exacerbated the uncertainty and confusion surrounding this issue. The time is ripe to resolve this conflict among the federal appellate courts and to decide whether ERISA prohibits the States from regulating stop-loss insurance.

CONCLUSION

For the reasons stated, this Court should issue a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit. Following review, the judgment should be reversed.

Respectfully submitted,

J. JOSEPH CURRAN, JR.
Attorney General of Maryland

ANDREW H. BAIDA
Assistant Attorney General
200 St. Paul Place, 20th Floor
Baltimore, Maryland 21202
(410) 576-6318

DENNIS W. CARROLL*
REN L. TUNDERMAN
Assistant Attorneys General
525 St. Paul Place, 2nd Floor
Baltimore, Maryland 21202
(410) 468-2030

*Counsel of Record

Attorneys for Petitioner

APPENDIX

TABLE OF CONTENTS

Page

April 11, 1997 Opinion of the United States Court of Appeals for the Fourth Circuit, 111 F.3d 358 . . . . . 1a

May 6, 1997 Order of the United States Court of Appeals for the Fourth Circuit, No. 96-1376 and 96-1446 . . . . . 16a

February 23, 1996 Opinion of the United States District Court for the District of Maryland, 915 F.Supp. 740 . . . . . 19a

March 12, 1996 Judgment of the United States District Court for the District of Maryland 35a

December 8, 1995 Order of the Maryland Insurance Commissioner in *In Re: Maryland Stop-Loss Regulation,* Case No. MIA-370-12/95 . . . . . 38a

Code of Maryland Regulation 09.31.02 . . . . . 56a

29 U.S.C. § 1144 . . . . . 60a

PUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

AMERICAN MEDICAL SECURITY, INCORPORATED; CLIENT FIRST BROKERAGE SERVICES, INCORPORATED; MARAN, INCORPORATED; TRIO METAL PRODUCTS COMPANY, INCORPORATED; UNITED WISCONSIN LIFE INSURANCE COMPANY,
Plaintiffs-Appellants,

v.

No. H-95-1446

DWIGHT K. BARTLETT, III, in his capacity as Insurance Commissioner of the State of Maryland,
Defendant-Appellee

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS; NATIONAL EMPLOYEE BENEFITS INSTITUTE; SELF-INSURANCE INSTITUTE OF AMERICA, INCORPORATED,
Amici Curiae.

Appeal from the United States District Court
for the District of Maryland, at Baltimore.
Alexander Harvey II, Senior District Judge.
(CA-95-1463-H)

Argued: October 28, 1996

Decided: April 11, 1997

Before NIEMEYER and MOTZ, Circuit Judges, and DOUMAR, Senior United States District Judge for the Eastern District of Virginia, sitting by designation.

Affirmed by published opinion. Judge Niemeyer wrote the opinion, in which Judge Motz and Senior Judge Doumar joined.

COUNSEL

ARGUED: Dennis William Carroll, Jr., Assistant Attorney General, MARYLAND INSURANCE ADMINISTRATION, Baltimore, Maryland, for Appellant. Edward J. Birrane, Jr., EDWARD J. BIRRANE, JR., CHARTERED, Towson, Maryland, for Appellees. **ON BRIEF:** J. Joseph Curran, Jr., Attorney General, Christina Gerstung Beusch, Assistant Attorney General, MARYLAND INSURANCE ADMINISTRATION Baltimore, Maryland, for Appellant. Andrew Jay Graham, Kathleen A. Birrane, KRAMON & GRAHAM, P.A., Baltimore, Maryland, for Appellees. Gregory B. Stites, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, Kansas City, Missouri, for Amicus Curiae Association. Joseph Semo, REINHART, BOERNER, VAN DEUREN, NORRIS & RIESEL- BACH, P.C., Washington, D.C., for Amicus Curiae Employee Benefits Institute. John H. Eggersten, Michael J. Friedman, HONIGMAN, MILLER, SCHWARTZ & COHN, Detroit, Michigan, for Amicus Curiae Self-Insurance Institute.

OPINION

NIEMEYER, Circuit Judge:

We must decide whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, preempts a Maryland insurance regulation that fixes the minimum attachment point for stop-loss insurance policies issued to self-funded employee benefit plans covered by ERISA. *See* Code of Maryland Regulations (hereafter "COMAR"), §9.31.02 (Health Insurance - Stop-

Loss Coverage). The state regulation is designed to prevent insurers and self-funded employee benefit plans from depriving plan participants and beneficiaries of state mandated health benefits. *See* 22 Md. Reg. 913 (1995).

The district court entered summary judgment declaring that ERISA preempts the state regulation and that the regulation is, therefore, "void to the extent that it mandates or affects attachment points for stop-loss insurance policies purchased by self-funded or self-insured employee benefit plans covered by ERISA." The Court also enjoined Maryland from enforcing the regulation or taking any other step "to regulate or affect the attachment points for stop-loss insurance policies purchased by self-funded or self-insured employee benefit plans."

Because the purpose and effect of Maryland's regulation is to force state-mandated health benefits on self-funded ERISA plans when they purchase certain types of stop-loss insurance, we hold that § 514(a) of ERISA, 29 U.S.C. § 1144(a), preempts the regulation, and, therefore, we affirm.

I.

Client First Brokerage Services, Incorporated; Maran, Incorporated; and Trio Metal Products Company, Incorporated, are Maryland employers sponsoring self-funded employee health benefit plans subject to ERISA. Each has purchased stop-loss insurance from United Wisconsin Life Insurance Company ("United Wisconsin Life") and has engaged American Medical Security, Incorporated, ("AMS") as administrator of their plans. These Maryland employers purchased stop-loss insurance to cover their plans' benefit payments above an annual

$25,000-per-employee level, known as the "attachment point." United Wisconsin Life was also agreeable to a lower attachment point, insuring a greater portion of the plans' payments, if requested to do so by the plans' sponsors. The stop-loss insurance afforded by United Wisconsin Life protected the plans themselves and not their participants or beneficiaries.

The employee benefit plans sponsored by these three Maryland employers contained substantially fewer benefits than the 28 mandated by Maryland for health insurance policies regulated by the Maryland Insurance Commissioner. *See* COMAR, § 09.31.05.03. The benefit plans sponsored by these Maryland employers did not, for example, include benefits for skilled nursing facility services, outpatient rehabilitative services, and certain organ transplants, all of which are mandated for inclusion in Maryland health insurance policies.

In the course of its review of United Wisconsin Life stop-loss policies in the fall of 1994 - insurance companies issuing policies to Maryland residents are required to obtain prior approval for their policies, *see* Md. Code, art. 48A, §§ 242 & 375 - the Maryland Insurance Agency disapproved United Wisconsin Life's stop-loss policies issued to the Maryland employers in this case because the attachment point was set informally at $25,000 and could be reduced at the employer's request. Since the policy could have an attachment point below $25,000 (the then mandated minimum), it was considered a policy of health insurance and, as such, was required to include mandated health benefits. *See* COMAR, §§ 9.31.02 & 9.31.05. Subsequently, the Maryland Insurance Commissioner dropped the minimum attachment point for stop-loss insurance to $10,000 of benefits paid to any single

beneficiary annually. The Commissioner also imposed a minimum aggregate attachment point of 115% of total benefit payments expected to be paid to all plan beneficiaries. COMAR, § 9.31.03B.

The Maryland employers, United Wisconsin Life, and AMS filed suit seeking a declaratory judgment that the regulations are not enforceable and an injunction against their enforcement. They alleged that Maryland's insurance regulations - which (1) establish a minimum attachment point for stop-loss insurance, and (2) deem stop-loss insurance policies with lower attachment points to be health insurance policies - improperly sought to regulate employee benefit plans in violation of ERISA's preemption provision. On cross motions for summary judgment, the district court agreed with the plaintiffs and
declared that ERISA preempts Maryland's regulations. This appeal followed.

II.

This case presents the tension between Maryland's effort to guarantee through its regulation of insurance that employee benefit plans offer at least 28 state-mandated health benefits, *see* COMAR, § 09.31.05, and Congress' preemption, through ERISA, of any state regulation that "relates to" an employee benefit plan, *see* 29 U.S.C. § 1144(a).

ERISA is a comprehensive federal statute regulating private employee benefit plans, including plans maintained for the purpose of providing medical or other health benefits for employees. To assure national uniformity of federal law, ERISA broadly preempts state law and assures that federal regulation will be exclusive. Section 514(a)

provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" as defined by ERISA. The courts have interpreted this clause broadly to carry out Congress' purpose of displacing any state effort to regulate ERISA plans. *See, e.g., FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) ("The preemption clause is conspicuous for its breadth"); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 98 (1983) ("The section's preemptive scope [is] as broad as its language"). Thus, any law that "relates to" a plan is preempted by § 514(a), and the phrase "relates to" is given its common sense meaning, as having "[1] connection with or [2] reference to such a plan." *Shaw*, 463 U.S. at 96-97; *see also District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 129 (1992).

Although ERISA'S preemptive scope is broad, the "savings clause" explicitly saves from ERISA's preemption those state laws that regulate insurance. *See* 29 U.S.C. § 1144(b)(2)(A). At the same time, however, the "deemer clause" provides that state insurance laws are not saved from preemption if they deem an employee benefit plan to be an insurance company in order to regulate it. *See* 29 U.S.C. § 1144(b)(2)(B); *see also Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987). Thus, a preempted law is saved from preemption if it regulates insurance and does not deem ERISA plans to be insurers for purposes of the state regulation of insurance. But at bottom, state insurance regulation may not directly or indirectly regulate self-funded ERISA plans. *See FMC*, 498 U.S. at 62. Accordingly, although plans that provide benefits in the form of insurance may be indirectly regulated through regulation of that insurance, *see id.* at 62-64, plans that are self-funded or self-insured may not themselves be regulated as insurance companies even if the self-funded or self-

insured plan purchases stop-loss insurance to cover losses or benefits payments beyond a specified level. *See Tri-State Machine, Inc. v. Nationwide Life Ins. Co.*, 33 F.3d 309, 315 (4th Cir. 1994); *Thompson v. Talquin Bldg. Prods. Co.*, 928 F.2d 649, 653 (4th Cir. 1991).

Stop-loss insurance provides coverage to self-funded plans above a certain level of risk absorbed by the plan. It provides protection to the plan, not to the plan's participants or beneficiaries, against benefit payments over the specified level, called the "attachment point." Attachment points may be "specific" or "aggregate." Specific attachment points define the level of benefits paid to individual beneficiaries beyond which the insurance company will indemnify the plan. Aggregate attachment points define the total number of benefits paid to all participants or beneficiaries beyond which the insurance company will indemnify the plan. Stop-loss insurance is thus akin to "reinsurance" in that it provides reimbursement to a plan after the plan makes benefit payments. *See* COMAR, § 09.31.02.02(5); *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 723 (2d Cir.), *rev'd on other grounds*, 115 S.Ct. 1671 (1994); *Thompson*, 928 F.2d at 653.

The State of Maryland regulates health insurance, requiring that health insurance policies afford at least 28 specified benefits. *See* COMAR, § 09.35.05. Apparently not wishing to be subject to state-mandated health benefits, insurance companies and their ERISA plan clients have entered into arrangements under which plans self-fund benefits and purchase stop-loss insurance to insure themselves against benefits paid beyond designated attachment points. A stop-loss policy does not itself provide coverage for benefits. Since such a policy insures only those benefits defined and actually paid by the plan, the ERISA plan's sponsor, not

state health insurance regulations, dictates the range of benefits provided. Thus, by absorbing a minimal amount of initial risk and insuring the remainder through stop-loss insurance, plans are able to provide health benefits of a kind or at a level different from what state law requires of health insurance.

Recognizing that such arrangements bypass Maryland's regulations for health insurance and intending to prevent such arrangements, the Maryland Insurance Commissioner adopted regulations that require plans to absorb the risk of at least the first $10,000 of benefits paid to each beneficiary. As the regulations' statement of purpose notes, the Commissioner seeks to protect Maryland residents "against acts by persons and insurers which deprive them of mandated health benefits." 22 Md. Reg. 913 (1995). Justifying the regulation and explaining how low attachment points permit self-funded ERISA plans to bypass state mandates, the Insurance Commissioner stated in his order:

> At very low attachment points, however, a "stop loss" policy is merely a substitution for health insurance. It does not insure only against catastrophic loss. The self-funded health benefit plan is not regulated by the Insurance Commissioner and is not required to provide any of the state-mandated benefits. The goal is obvious: As policies become available with attachment points lower than many deductibles, it became an increasingly attractive option to "self-insure" a health plan, but to continue to shift the majority of the risk to the insurance carrier by purchasing "stop-loss" coverage.

In re: Maryland Stop Loss Insurance Litigation, No. MIA-370-12195 at 4 (Dec. 8, 1995). The regulations accordingly

provide that any stop-loss insurance policy with a specific attachment point below $10,000 is deemed to be a health insurance policy for purposes of Maryland's health insurance regulations and must therefore contain mandated benefits. *See* COMAR § 09.31.02.03. On the other hand, if the specific attachment point is above $10,000 and the policy provides for payment only to the plan, and not to its participants and beneficiaries, it is considered to be traditional stop-loss insurance that essentially reinsures the risks defined by the plan. *See id.*

In summary, on one side of the issue before us, the Maryland Insurance Commissioner seeks to take advantage of his right under ERISA's savings clause to regulate the business of insurance. And on the other side, the insurance companies seek to take advantage of ERISA's preemption and deemer clauses to remove self-funded plans from the reach of state insurance regulation.

III.

We begin the analysis with the question of whether Maryland's regulations "relate to" ERISA employee benefit plans and thus whether they fall within ERISA's preemptive scope. *See* 29 U.S.C. § 1144(a). A regulation relates to an employee benefit plan when it has a "connection with or reference to such a plan." *Shaw*, 463 U.S. at 96-97. The Maryland Insurance Commissioner wisely concedes that the regulations at issue do "relate to" ERISA plans. By their own terms, the stop-loss insurance regulations apply to "an employer's health plan," *i.e.*, an ERISA health plan. *See* COMAR, § 09.31.02.02(4). "[W]here the existence of ERISA plans is essential to the [state] law's operation, . . . that 'reference' will result in preemption." *California Div'n of Labor Standards Enforcement v. Dillingham Constr.*,

N.A., 117 S.Ct. 832, 838 (1997) (noting that state law that "has a connection with" or "reference to" an employee benefit plan is preempted). By virtue of the regulations' "reference to" ERISA plans, they "relate to" ERISA plans and fall within the scope of ERISA's preemption provision, 29 U.S.C., § 1144(a). *See Greater Washington Bd. of Trade*, 506 U.S. at 129.

Even though Maryland's regulations relate to ERISA plans, they nevertheless may be saved from preemption if they constitute a law that "regulates insurance," *see* 29 U.S.C. § 1144(b)(2)(A), without deeming an ERISA plan to be an insurance company or other insurer, *see* 29 U.S.C. § 1144(b)(2)(B). In determining whether a state law is one that "regulates insurance," it is not enough that it operate only on insurance companies or insurance policies. The regulation must regulate the business of insurance in the sense that the object of its regulation (1) "has the effect of transferring or spreading a policyholder's risk"; (2) "is an integral part of the policy relationship between the insurer and the insured"; and (3) "is limited to entities within the insurance industry." *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724, 743 (1985).

In this case, the Maryland Insurance Commissioner can well argue with respect to the first *Metropolitan Life* factor that the setting of attachment points allocates risk. Higher attachment points burden plans with more risk while lower attachment points increase insurance company risk. The Commissioner might also be able to argue successfully on the second *Metropolitan Life* factor that the regulations address a practice integral to the insured-insurer relationship, at least if our analysis is limited to the explicit terms of the regulations. The regulations, by their own terms, seek to impose requirements only on insurance

companies and their stop-loss insurance policies. This factor is, however, complicated by the fact that the intended, stated, and actual effect of the regulations is to reach the relationship between ERISA plans and their participants who are not parties to the insurance contract. The third *Metropolitan Life* factor is complicated in the same way. Although the state's regulation of attachment points is limited to entities in the insurance industry, the stated purpose of the regulations is also to reach the plan-participant relationship, a relationship which is outside the insurance industry.

While the Maryland Insurance Commissioner can thus make a superficial case that the regulations address the business of insurance, the complications of the second and third *Metropolitan Life* factors together with the "deemer clause" provide the core difficulty with the state's regulation of stop-loss insurance policies issued to ERISA plans.

We recognize that the regulations are carefully drafted to focus directly on insurance companies issuing stop-loss insurance and not on the employee benefit plans themselves. Thus, the regulations purport to define stop-loss insurance as health insurance subject to state regulation if the stop-loss insurance meets specific criteria. Notwithstanding the regulations' wording, however, their purpose and effect are directed at self-funded employee benefit plans that attempt to provide fewer health benefits to Maryland residents than state law mandates for health insurance policies. The state asserts a need for this regulation because, in its absence, the loophole would allow every self-funded plan to provide coverage for fewer health benefits than state law mandates for health insurance policies. It argues that absorbing a minimal risk is simply

a sham to circumvent state insurance regulation, the area carved out by ERISA in which states may act. But in seeking to address this perceived loophole, the state in fact ends up regulating self-funded employee benefit plans that are exclusively subject to ERISA.

In seeking to require self-funded plans to offer coverage consistent with state insurance law, Maryland crosses the line of preemption. Even though the regulatory language targets stop-loss insurance policies, the Commissioner's stated purpose is to protect Maryland residents from self-funded ERISA plans and insurers "which deprive them of mandated health benefits." 22 Md. Reg. 913 (1995). The regulations thus use stop-loss insurance policies as a vehicle to impose the requirements of Maryland health insurance law on self-funded ERISA plans. By aiming at the plan-participant relationship, Maryland law violates the ERISA provision that no ERISA plan "shall be deemed to be an insurance company . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts." 29 U.S.C. § 1144(b)(2)(B).

The state's fear that plans will circumvent state regulation and offer citizens too few health benefits is understandable. But to state that fear reveals that Maryland is really concerned, not with the business of insurance and its coverage of risks, but with the benefits that ERISA plans can choose to provide their participants and beneficiaries. No matter how understandable this concern may be, only Congress may address it, not the State of Maryland through its insurance regulations. In attempting to address this concern through the regulation of stop-loss insurance, the state blurs the real distinction between self-funded plans, with or without stop-loss insurance, and fully insured plans.

Maryland's regulations distinguish self-funded plans from insured plans solely based on the level of the attachment point of stop-loss insurance. Thus, when the attachment point becomes low, Maryland deems self-funded plans with stop-loss insurance to be insured plans. *See* COMAR, § 09.35.02.02. This distinction overlooks the real risks.

Under a self-funded plan, the employer who promises the benefit incurs the liability defined by the plan's terms. That liability remains the employer's even if it has purchased stop-loss insurance and even if the stop-loss insurer becomes insolvent. Conversely, if the employer becomes insolvent, the solvency of the stop-loss insurer may not benefit plan participants and beneficiaries. This is because their claims against the insurer would be derivative of the plan's claim against the insurer, which arises only after the plan actually makes benefit payments beyond the agreed attachment point. In contrast, when a plan buys health insurance for participants and beneficiaries, the plan participants and beneficiaries have a legal claim directly against the insurance company, thereby securing the benefits even in the event of the plan's insolvency. Participants and beneficiaries in self-funded plans may not have the security of the insurance company's assets because stop-loss insurance insures the plan and not the participants.

The state's regulations fail to recognize that in a self-funded plan, with or without stop-loss insurance and regardless of the attachment point, the provision of benefits depends on the plan's solvency, whereas the provision of benefits in an insured plan depends entirely on the insurer's solvency. It is this fundamental difference that precludes the Maryland Insurance Agency from regulating self-funded plans but permits them to regulate insurance companies that

provide health benefits to plans for their participants. While ERISA's savings clause explicitly empowers states to adjust the obligations and incentives which bear on insurance companies' solvency, *see* 29 U.S.C. § 1144(b)(2)(A), the combined effect of the preemption and deemer clauses, 29 U.S.C. § 1144(a) & (b)(2)(B), is that ERISA plan solvency is the purview of federal law alone.

Maryland's stop-loss insurance regulations also directly and impermissibly affect ERISA plans' costs and choices in designing their own array of benefits. If a self-funded plan insured by stop-loss insurance having an attachment point of $5,000 provided no benefit for organ transplants, the regulations would either raise plan costs by including unwanted, state-mandated insurance coverage for organ transplants or convert the self-funded plan into a fully insured plan contrary to its preference. These effects impermissibly intrude on the relationship between an ERISA plan and its participants and beneficiaries.

While we recognize that self-funded plans may not be providing Maryland residents with the range of benefits mandated by state law and that such plans' benefits may not always be as secure as those offered by regulated insurance companies, the remedy for any such deficiency must be requested of Congress. When ERISA preempted state law relating to ERISA-covered employee benefit plans, it may have created a regulatory gap, but Maryland is without authority to fill that gap. *See Greater Washington Bd. of Trade*, 506 U.S. at 130-31 (D.C. workers' compensation provision requiring the provision of benefits in proportion to covered benefits to ERISA plan "relates to" and is therefore preempted by ERISA); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981) ("even indirect state action bearing on [ERISA plans] may encroach upon

the area of exclusive federal concern"). This is not to say that Maryland may not regulate stop-loss insurance policies. Such regulation is clearly reserved to the states. *See* 15 U.S.C. § 1012(a) (The "business of insurance, and every person engaged therein, shall be subject to the laws of the several states"); 29 U.S.C. § 1144(b)(2) (ERISA does not preempt "any law of any State which regulates insurance" unless it deems a plan to be "an insurance company"). But because the Maryland regulation before us attempts to mandate the benefits that certain self-insured plans may offer, we affirm the judgment of the district court.

AFFIRMED

FILED: May 6, 1997

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 96-1376
CA-95-1463-H

AMERICAN MEDICAL SECURITY, INC.; CLIENT FIRST BROKERAGE SERVICES, INC.; MARAN, INC.; TRIO METAL PRODUCTS COMPANY, INC.; UNITED WISCONSIN LIFE INSURANCE COMPANY

Plaintiffs - Appellees

v.

DWIGHT K. BARTLETT, III, in his capacity as Insurance Commissioner of the State of Maryland

Defendant - Appellant

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS; NATIONAL EMPLOYEE BENEFITS INSTITUTE; SELF-INSURANCE INSTITUTE OF AMERICA, INC.

Amici Curiae

No. 96-1446
CA-95-1463-H

AMERICAN MEDICAL SECURITY, INC.; CLIENT FIRST BROKERAGE SERVICES, INC.; MARAN, INC.; TRIO METAL PRODUCTS COMPANY, INC.; UNITED WISCONSIN LIFE INSURANCE COMPANY

Plaintiffs - Appellants

v.

DWIGHT K. BARTLETT, III, in his capacity as Insurance Commissioner of the State of Maryland

Defendant - Appellee

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Amicus Curiae

and

NATIONAL EMPLOYEE BENEFITS INSTITUTE; SELF-INSURANCE INSTITUTE OF AMERICA, INC.

Amici Curiae

On Petition for Rehearing with Suggestion for Rehearing in Banc

---

The appellants' petition for rehearing and suggestion for rehearing in banc were submitted to this Court. As no member of this Court or the panel requested a poll on the suggestion for rehearing in banc, and

As the panel considered the petition for rehearing and is of the opinion that it should be denied,

IT IS ORDERED that the petition for rehearing and suggestion for rehearing in banc are denied.

For the Court,

/s/ Patricia S. Connor

Clerk

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MARYLAND

AMERICAN MEDICAL SECURITY, INC.; CLIENT FIRST BROKERAGE SERVICES, INC.; MORAN, INC.; TRIO METAL PRODUCTS COMPANY, INC., AND UNITED WISCONSIN LIFE INSURANCE COMPANY	:	
Plaintiffs,	:	
	:	Civil No. H-95-1463
vs.	:	
DWIGHT K. BARTLETT, III, Commissioner, Maryland Insurance Administration,	:	
Defendant.	:	

HARVEY, Senior District Judge

DATED: February 23, 1996

Edward J. Birrane, Jr., Towson, Md., and Andrew Jay Graham and Kramon and Graham, Baltimore, Md., for plaintiffs.

Christina Gerstung Beusch, Assistant Attorney General, Baltimore, Md., for defendant.

In this civil action, the plaintiffs challenge a regulation ("the Regulation") promulgated by defendant Dwight K. Bartlett, III, Commissioner of the Maryland Insurance Administration ("the Commissioner"). The parties have undertaken discovery, and both the plaintiffs and the defendant have filed a motion for summary judgment.

The question of law presented by the pending motions is whether the Regulation, which concerns so-called "stop-loss" insurance issued by insurers to employee benefit plans, is preempted by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001, et seq. The five plaintiffs have here filed a three-count complaint, seeking injunctive and declaratory relief. Plaintiffs ask the Court to enter a judgment declaring (1) that ERISA preempts the Commissioner and the State of Maryland from enforcing any regulation or statute, or any decision or action having the effect of law, as respects any stop-loss policy issued to an employee benefit plan covered by ERISA, and (2) that the Commissioner and the State of Maryland are preempted from regulating the so-called attachment points of stop-loss insurance policies.[1] Plaintiffs also seek an award of attorneys' fees and costs.

---

[1] In Count Three of their complaint, plaintiffs also seek an injunction and a judgment declaring that defendant's attachment point requirements are unenforceable under Maryland law. Plaintiffs have not, however, sought summary judgment as to this Count. At the hearing held on the pending motions, counsel for plaintiffs indicated that they would agree to a dismissal without prejudice of Count Three, if their motion for summary judgment were granted as to Counts One and Two.

In support of their motions, the parties have submitted lengthy memoranda and numerous exhibits. A hearing has been held in open court. For the reasons to be stated herein, plaintiffs' motion for summary judgment will be granted, and defendant's motion for summary judgment will be denied. Count Three of the complaint will be dismissed without prejudice.

I.

Employee Benefit Plans Under ERISA

An "employee benefit plan" under ERISA includes a plan established or maintained by an employer to the extent that such plan was established or is maintained for the purpose of providing for its participants or their beneficiaries, medical, surgical, or hospital care or benefits. 29 U.S.C. § 1002(1). A plan may be fully insured, self-insured, self-funded, or a combination thereof. A fully insured plan purchases a group health insurance policy in order to fund its benefits. A self-funded plan pays benefits out of a pool of money collected from the plan's own funds, from employee contributions, or from both. A self-insured plan also pays benefits out of its own funds, but the money comes from the employer's general funds and not from a separate pool.[2]

Self-insured and self-funded plans often purchase so-called "stop-loss" insurance in order to limit the financial risk which the plan might face in the event of catastrophic

---

[2] For purposes of the pending motions, there is no distinction between a self-funded plan and a self-insured plan.

health care expenses. Stop-loss insurance reimburses the employee benefit plan for claims that exceed a certain agreed-upon amount, the so-called "attachment" point. There are two types of attachment points: specific (or individual) and aggregate. A specific attachment point represents the amount above which the stop-loss carrier must reimburse the plan for eligible claims made by an individual plan participant during the plan year. The specific attachment point protects the plan against exceptionally high claims made by an individual participant. An aggregate attachment point represents the amount above which the stop-loss carrier must reimburse the plan for all eligible claims during the plan year.[3] The aggregate attachment point protects the plan against the risk of higher than expected total claims made by plan participants.

Stop-loss coverage insures the employee benefit, plan, not the individual participants in the plan. Thompson v. Talquin Bldg. Prods. Co., 928 F.2d 649, 653 (4th Cir. 1991). Therefore, the purchase of stop-loss insurance does not relieve the plan of its obligation to pay benefits to plan participants, and the stop-loss insurer has no obligation to pay claims of plan participants. Id. Moreover, the purchase of stop-loss insurance does not convert a self-funded or self-insured employee benefit plan into a fully insured plan for preemption purposes. Id.; Tri-State Mach., Inc. v. Nationwide Life Ins. Co., 33 F.3d 309, 315 (4th Cir. 1994), cert. denied, 115 S.Ct. 1175 (1995). For the purposes of ERISA, a plan remains self-funded even though covered by stop-loss insurance. Id.

---

[3] The aggregate attachment point is typically expressed as a percentage of total expected claims, but may be a specific dollar amount.

II.

Background Facts

The Regulation at issue in this case was propounded by defendant Dwight K. Bartlett, III, in his official capacity as Insurance Commissioner of the State of Maryland. Plaintiffs are American Medical Security, Inc. ("AMS"), Client First Brokerage Services, Inc. ("Client First"), Moran, Inc. ("Moran"), Trio Metal Products Company, Inc. ("Trio Metals"), and United Wisconsin Life Insurance Company ("UWLIC"). UWLIC is licensed and authorized to engage in the business of life and health insurance in the State of Maryland. UWLIC sells stop-loss coverage to self-funded and self-insured employee benefit plans. AMS is a licensed third-party administrator which processes health benefit claims on behalf of self-funded plans that have purchased stop-loss insurance from UWLIC. Client First, Moran and Trio Metals are Maryland corporations which maintain self-funded plans, and each of these small employers has purchased from UWLIC stop-loss insurance administered by AMS. The specific attachment point of the stop-loss policy issued to Client First is $25,000, the Moran specific attachment point is $3,000, and the Trio Metals specific attachment point is $2,500.[4]

The stated purposes of the Regulation are to define when stop-loss coverage will be considered to be health insurance, and to establish that the purpose of true stop-loss coverage is to cover catastrophic losses of the policyholder.

---

[4]Due to enrollment additions, terminations, and changes, the aggregate attachment point under each policy cannot be calculated until the end of the plan year.

COMAR § 09.31.02. Essentially, the Regulation defines "stop-loss insurance" by setting out certain requirements for an insurance policy to qualify as such. Among these requirements are that, if a policy contains a specific attachment point, it must be at least $10,000 per participant per year, and that if the policy contains an aggregate attachment point, it must be at least 115% of expected claims for all participants. COMAR § 09.31.02.03B. A stop-loss policy need not contain both type of attachment points, but the attachment point which it does contain must meet the minimum requirements of the Regulation.

A "stop-loss" policy which does not satisfy the minimum requirements of the Regulation is considered to be a standard health insurance policy, required by Maryland law to provide specific benefits.[5] Thus, the Regulation attempts to prevent small employers like Client First, Moran and Trio Metals from avoiding the minimum health insurance coverage required by Maryland law. If a stop-loss policy issued to such an employer contains a low attachment point, then the stop-loss coverage attached at a very early time, and the stop-loss carrier essentially acts as a typical insurer the obligations of which arise after a specified deductible is satisfied. In this manner, a self-funded or self-insured plan bears very little responsibility for making benefit payments itself, and at the same time it

---

[5] Under the Maryland Health Insurance Reform Act of 1993, the only health insurance which may be sold to an employer having between two and fifty employees is the Comprehensive Standard Health Benefit Plan established by the Act. Md. Ann. Code art. 48A §§ 698-713. This standard plan contains some 37 required benefits. COMAR §§ 09.31.05.01-.11.

avoids the minimum coverage mandated by Maryland law.[6] As intended, the effect of the Regulation is to force a small employer to either bear more risk by means of the adoption of a higher attachment point, or to abandon self-funding and purchase a health insurance policy which would include state-mandated coverage. Plaintiffs contend that a third option exists, namely that a self-funded plan might decide not to purchase stop-loss insurance, and thereby risk insolvency if forced to pay exceptionally high claims.

III.

Discussion

ERISA in general preempts "any and all State laws" insofar as they "relate to any employee benefit plan" covered by ERISA. 29 U.S.C. § 1144(a). However, a state law "which regulates insurance, banking or securities" is not preempted, pursuant to the so-called "saving clause" of ERISA. 29 U.S.C. § 1144(b)(2)(A). The "saving clause" is in turn limited by the so-called "deemer clause," which provides that no employee benefit plan "shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . ." 29 U.S.C. § 1144(b)(2)(B).

---

[6] According to the Commissioner, the current Moran plan provides 9 of the 37 required benefits, and the current Trio Metals plan provides 15 of the 37 required benefits. No analysis of the Client First plan was done because the $25,000 specific attachment point in that policy would satisfy the definition of "stop-loss insurance" in the Regulation.

The Supreme Court has explained that ERISA's preemption clause

> establishes as an area of exclusive federal concern the subject of every state law that "relate[s] to" an employee benefit plan governed by ERISA. The saving clause returns to the States power to enforce those state laws that "regulate[e] insurance," except as provided in the deemer clause. Under the deemer clause, an employee benefit plan governed by ERISA shall not be "deemed" an insurance company, an insurer, or engaged in the business of insurance for purposes of state laws "purporting to regulate" insurance companies or insurance contracts.

FMC Corp. v. Holliday, 498 U.S. 52, 58 (1990). In a number of cases, the Supreme Court has noted the exceptional breadth of preemption under ERISA. See, e.g., id.; Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47 (1987); Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739 (1985); Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 90 (1983).

(a)

Does the Regulation "Relate To" an Employee Benefit Plan?

Initially, this Court must determine whether the Regulation "relates to" an employee benefit plan covered by ERISA. A law "relates to" an employee benefit plan if it has a "connection with or reference to" such a plan. Shaw, 463 U.S. at 97. The Court in this case must therefore first determine whether the Regulation refers to employee benefit plans, or is connected to such plans, and accordingly

is subject to preemption under § 1144(a).

The Supreme Court has "virtually taken it for granted that state laws which are 'specifically designed to affect employee benefit plans' are preempted under [§ 1144(a)]." Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 829 (1988). In pertinent part, the Regulation states:

> A policy or contract issued to an employer may be considered to be a policy or contract of stop-loss health insurance coverage only if:
>
> (1) The stop-loss coverage is issued to and insures the sponsor or administrator of the plan or the plan itself and is not issued to employees, dependents, members, or participants;
>
> (2) The carrier is liable for payment only to the sponsor or administrator of the plan or the plan itself and not to the employees, dependents, members, subscribers, participants, or providers . . .

From its review of this portion of the Regulation, this Court concludes that the quoted language appears to be "specifically designed to affect employee benefit plans," especially in light of the Commissioner's statement that a purpose of the Regulation is to limit the amount of risk that a self-funded plan can cede to its stop-loss insurer. Such a limitation is aimed at preventing small employers from self-funding their plans in order to avoid state mandated benefits.

In arguing that the Regulation does not "relate to" an ERISA plan, defendant relies on the recent Supreme Court decision in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers, Ins. Co., 115 S.Ct. 1671 (1995). But the facts of that case are distinguishable from those present here. The Supreme Court in Travelers criticized the broad definition of "relates to" in Shaw, and ultimately found that the surcharge system at issue in that case had no "connection with" employee benefit plans because it merely had an indirect economic effect on the relative costs of various health insurance packages available to plan administrators. Id. at 1680. In the present case, however, the Regulation applies specifically to stop-loss insurance sold only to benefit plans. Here, there is a much greater connection between the Regulation and an ERISA benefit plan than existed under the more generally applicable surcharge system in Travelers. The Regulation at issue in this case thus goes well beyond the indirect effects of the surcharge system in Travelers and imposes significant restrictions on plan administration and operation.

On the record here, this Court concludes that the Regulation was designed to affect employee benefit plans, that it therefore "relates to" an ERISA plan and that it is subject to preemption under § 1144(a).

(b)

Is the Regulation "Saved" from Preemption?

Because the Regulation relates to an employee benefit plan, it is preempted unless it falls within the "saving clause" and does not violate the "deemer clause." In general, a state law is protected by the "saving clause" if it

"regulates insurance." 29 U.S.C. § 1144(b)(2)(A). However, this protection is lost if the law, in purporting to regulate insurance, deems a plan to be "an insurance company or other insurer . . . or to be engaged in the business of insurance. . ." 29 U.S.C. § 1144(b)(2)(B). Although the parties have discussed in great detail the various tests to be applied by a court in determining whether a state law "regulates insurance," applicable case law indicates that because of the "deemer clause," the "saving clause" does not under the circumstances of this case protect the Regulation from preemption.

The Regulation "directly controls the terms of insurance contracts" by mandating, inter alia, minimum attachment points in order for a policy to be considered stop-loss insurance. See FMC Corp., 498 U.S. at 61. The Regulation therefore would typically fall within the protection of the "saving clause" and not be preempted, as long as it did not violate the "deemer clause." The Fourth Circuit, however, has held that "[a]lthough under the 'saving clause,' any state law regulating insurance policy terms withstands ERISA preemption, self-funded employee benefit plans are not covered by the clause." Thompson, 928 F.2d at 649, citing FMC Corp., 498 U.S. at 61; Metropolitan Life, 471 U.S. at 747; Powell v. Chesapeake and Potomac Tel. Co. of Va., 780 F.2d 419, 423 (4th Cir. 1985), cert. denied, 476 U.S. 1170 (1986). This Court therefore concludes that in this particular case the "saving clause" is inapplicable, and the Regulation is preempted because of the interaction between the "saving clause" and the "deemer clause."

As stated by the Supreme Court,

> We read the deemer clause to exempt self-funded ERISA plans from state laws that "regulat[e]

> insurance" within the meaning of the saving clause. By forbidding States to deem employee benefit plans "to be an insurance company or other insurer . . . or to be engaged in the business of insurance," the deemer clause relieves plans from state laws "purporting to regulate insurance." As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation "relate[s] to" the plans. State laws directed toward the plans are preempted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws.

FMC Corp., 498 U.S. at 61.

As the Supreme Court has recognized, fully insured plans are not subject to ERISA preemption.

> On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.

Id. As the Court explained, "the deemer clause makes clear that if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it."[7] Id. at 64. Plaintiffs assert that the self-funded plans of Client First, Moran, and Trio Metals are uninsured and therefore not subject to state regulation. This Court would agree.

Defendant argues that, because the plans at issue here purchase stop-loss insurance, they are subject to indirect regulation to the same extent as fully insured plans. According to defendant, the Regulation controls the terms of insurance policies, which is a permissible means of regulating an insured plan. See id. at 61; Metropolitan Life, 471 U.S. at 746-47. Defendant focuses on the fact that the plans in fact purchase insurance, and argues that they must therefore be considered to be insured and subject to indirect regulation, whether or not they are primarily self-funded.

Whatever plausibility such an argument may have, the Court must reject it under applicable Fourth Circuit law. While it is true that the Client First, Moran, and Trio Metals plans purchase insurance, those plans are not considered "insured" plans as that term has been construed in ERISA cases. The Fourth Circuit has specifically held that "stop-

---

[7]Although the Supreme Court has recognized that, for purposes of a preemption issue, there exists a distinction between insured and uninsured plans, "leaving the former open to indirect regulation while the latter are not . . .", the Court has further observed that "[a]rguments as to the wisdom of these policy choices must be directed at Congress." Metropolitan Life, 471 U.S. at 747.

loss insurance does not convert [a] self-funded employee benefit plan into an insured plan." Thompson, 928 F.2d at 653; see also Tri-State Mach., Inc. v. Nationwide Life Ins. Co., 33 F.3d 309, 315 (4th Cir. 1994), cert. denied, 115 S.Ct. 1175 (1995); United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga, 801 F.2d 1157, 1161-62 (9th Cir. 1986). There is a distinction between a group health insurance policy purchased by a fully insured plan, whereby the participants receive benefit payments directly from the insurer, and a stop-loss insurance policy purchased by a self-funded or self-insured plan, whereby the plan itself receives the benefit payment. The purpose of stop-loss insurance is to protect the plan from catastrophic losses and not to provide health and accident insurance directly to employees. Thompson, 928 F.2d at 653. Accordingly, this Court concludes that the self-funded plans at issue in this case cannot be considered to be insured and subject to indirect State regulation for purposes of determining whether there is ERISA preemption.

In sum, the Regulation directly regulates insurance and therefore would be "saved." However, applying principles enunciated by the Supreme Court and the Fourth Circuit, the Regulation cannot reach the self-funded plans of plaintiffs Client First, Moran, and Trio Metals because those plans may not be deemed to be insurance companies or other insurers. See FMC Corp., 498 U.S. at 61. "State laws that directly regulate insurance are 'saved' but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws." Id. Moreover, the purchase of stop-loss insurance does not strip the plans of their self-funded status. Thompson, 928 F.2d at 652-53; Tri-State

Mach., 33 F.3d at 315.

For these reasons, the Court concludes that the State of Maryland may not regulate the self-funded and self-insured benefit plans at issue in this case by mandating minimum attachment points for stop-loss insurance. The Regulation is therefore preempted by ERISA.

IV.

Attorneys' Fees and Costs

In their complaint, plaintiffs seek, inter alia, an award of attorneys' fees and costs under 29 U.S.C. § 1132(g)(1). That statute permits the court in its discretion to allow "a reasonable attorney's fee" and costs in an action brought by a participant, beneficiary, or fiduciary.

Neither plaintiffs nor defendant have addressed in their motions for summary judgment plaintiffs' claim for an award of attorneys' fees and costs. Only in plaintiffs' opposition to defendant's motion for summary judgment was this issue briefly discussed.

In Reinking v. Philadelphia Am. Life Ins. Co., 910 F.2d 1210, 1217-18 (4th Cir. 1990), the Fourth Circuit adopted a five factor test to be applied by a court in awarding attorneys' fees under ERISA. Since that test has not been adequately addressed by the parties in light of the circumstances here, the Court will not at this time rule on plaintiffs' request for an award of attorneys' fees. Plaintiffs should file an appropriate motion under Local Rule 109.2, seeking attorneys' fees and costs under § 1132(g)(i). That motion should then be briefed by the parties pursuant to

Local Rule 105.2. The Court will later determine whether plaintiffs are entitled to such an award and, if so, the amount to be awarded.

V.

Conclusion

For all the reasons stated, the Court will grant plaintiffs' motion for summary judgment as to Counts One and Two, and will dismiss, without prejudice, Count Three of the complaint. Defendant's motion for summary judgment will be denied. Plaintiffs should submit to the Court within 10 days a proposed declaratory judgment order. Plaintiffs should thereafter file an appropriate motion seeking attorneys' fees and costs pursuant to Local Rule 109.2.

Alexander Harvey, II
Senior United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

AMERICAN MEDICAL SECURITY, INC.; CLIENT FIRST BROKERAGE SERVICES, INC.; MORAN, INC.; TRIO METAL PRODUCTS COMPANY, INC., AND UNITED WISCONSIN LIFE INSURANCE COMPANY	:	
Plaintiffs,	:	
	:	Civil No. H-95-1463
vs.	:	
DWIGHT K. BARTLETT, III, Commissioner, Maryland Insurance Administration,	:	
Defendant.	:	

JUDGMENT

This matter having come before the Court for consideration of summary judgment motions filed in the above entitled case by all parties; and this Court having carefully reviewed briefs and exhibits submitted in support of and in opposition to the motions, and having heard oral argument from counsel for the parties thereon; and this Court having rendered its Opinion in this matter on February 23, 1996, it is this 12th day of March, 1996 by the United States District Court for the District of Maryland.

ORDERED:

1. That Count Three of the Complaint is dismissed without prejudice;

2. That the motion for summary judgment filed by the defendants as to Counts One, Two and Three of the Complaint is denied;

3. That the motion for summary judgment filed by the plaintiffs as to Counts One and Two of the Complaint is granted;

4. That Judgment is hereby entered in favor of plaintiffs, with costs; and

5. That pursuant to 28 U.S.C. §§ 2201 and 2202, it is the FINDING and DECLARATION of this Court that:

a. The Employee Retirement Income and Security Act ("ERISA"), 28 U.S.C. § 1001, et seq. (1979) preempts the Insurance Commissioner of the State of Maryland (and any other person authorized by the State of Maryland to promulgate any regulation, statute or any decision or action having the effect of law) from promulgating or enforcing, directly or indirectly, any regulation, statute or decision that mandates or affects attachment points for stop-loss insurance policies purchased by self-funded or self-insured employee benefit plans covered by ERISA;

b. The regulation published as Code of Maryland Regulations ("COMAR") § 09.31.02 and entitled "Health Insurance-Stop-Loss Coverage" ("the Regulation") is preempted by ERISA and therefore is void to the extent that it mandates or affects attachment points for stop-loss

insurance policies purchased by self-funded or self-insured employee benefit plans covered by ERISA; and

6. That defendant, the Insurance Commissioner and the State of Maryland and its agents, employees and officials are prohibited and ENJOINED from enforcing the Regulation or otherwise attempting, by any means, to regulate or affect the attachment points for stop-loss insurance policies purchased by self-funded or self-insured employee benefit plans that exist or are hereafter formed under the Employee Retirement Insurance Security Act of 1974, as amended.

Alexander Harvey, II
Senior United States District Judge

STATE OF MARYLAND
MARYLAND INSURANCE ADMINISTRATION

IN RE:	:	
MARYLAND STOP LOSS INSURANCE REGULATION	:	CASE NO. MIA-370-12/95

ORDER

I. Introduction

On June 9, 1995, the Maryland Insurance Administration published a proposed regulation in the Maryland Register, 22 Md. Reg. 913 (June 9, 1995). This regulation defines and distinguishes stop loss insurance and health insurance under the Insurance Code. As part of this definition, the regulation sets attachment points of $20,000 on an individual basis and 125% of expected claims on an aggregate basis for policies which are to be considered stop loss. On August 24, 1995, following the standard 30 day comment period during which written comments were received, the regulation was published as a final regulation with an effective date of September 24, 1995, to apply to all policies issued or renewed after January 1, 1996.

After the publication of the final regulation, I received numerous comments opposing its implementation. In

addition, I was made aware of the fact that the actuarial firm of Milliman and Robertson had performed an additional study which was not available at the time the original regulation was promulgated. This study suggested that an attachment point lower than $20,000 may be appropriate.

In light of these developments, I determined that a public hearing was appropriate. This hearing was held on November 13, 1995. Numerous witnesses testified regarding various preferred attachment points and the impact of the regulation on Maryland businesses.

I have carefully reviewed the testimony from the public hearing, written submissions received both before and after the hearing, and actuarial studies and materials relied on in the adoption of COMAR 09.31.02. Based on this review, I have determined to modify the regulation. As set forth below, I have concluded that a specific attachment point of $10,000 and an aggregate attachment point of 115% of expected claims are appropriate. While higher levels can easily be justified, the new levels will have less of an impact on the business community in Maryland and at the same time carry out what I perceive to be important public policies of the State. Accordingly, I will immediately promulgate new regulations to reflect these modifications.

II. Background

Stop loss insurance is insurance purchased from a licensed carrier by a self-insured health plan. Stop loss coverage is intended to insure only against catastrophic or unexpected losses of the policyholder/employer who retains a majority of the risk of loss on himself. The plan, not its participants, is the beneficiary of the stop loss policy. A

stop loss policy contains an attachment point above which the insurer reimburses the plan for claims paid. Payment of claims below the attachment point is the responsibility of the plan and is not reimbursable. The attachment point is usually described in two ways: (1) a maximum amount per person per benefit year, generally with a lifetime cap; and (2) an aggregate amount, which is generally 100% or more of expected claims for the year. The specific attachment point protects the plan against catastrophic loss resulting from the severe illness or injury of one or more individuals during the benefit year. The aggregate attachment point protects against catastrophic loss to the plan if many plan participants become ill or injured resulting in higher than expected total claims for the self-insured group in a single year.

The Maryland Insurance Commissioner has regulated stop loss insurance and the appropriate attachment point levels for over twenty years. Policy forms for all insurance products sold in Maryland are required to be submitted for approval under the Insurance Code. Since the mid 1980's the Maryland Insurance Administration and its predecessor, the Insurance Division of the Department of Licensing and Regulation, employed a minimum specific attachment point of $25,000 as well as a variable aggregate attachment point. A policy which did not contain these attachment points would not be approved as a policy of stop loss insurance. Any policy with attachment points lower than these levels was considered to be a policy of health insurance and, as such, was required to offer the mandated benefits passed by the General Assembly. This long-standing interpretation and policy was never promulgated in regulations, but nonetheless was consistently applied over the years.

During 1993 and 1994, the Insurance Administration received a number of complaints regarding the availability in the marketplace of stop loss policies with specific attachment points as low as $500 or $1,000. It appears that the emergence of extremely 'ow attachment points coincided with the implementation of House Bill 1359, the Maryland Health Insurance Reform Act of 1993. At very low attachment points, however, a "stop loss" policy is merely a substitution for health insurance. It does not insure only against catastrophic loss. The self-funded health benefit plan is not regulated by the Insurance Commissioner and is not required to provide any of the state-mandated benefits. The goal is obvious: As policies became available with attachment points lower than many deductibles, it became an increasingly attractive option to "self-insure" a health plan, but to continue to shift the majority of the risk to the insurance carrier by purchasing "stop loss" coverage.

The effect of having a low attachment point is that the insurance carrier issuing the "stop loss" coverage is, in reality, providing direct health insurance. The attachment point is merely a deductible. The licensed carrier therefore avoids all mandates and all consumer protections. Insurers selling approved products spend a great deal of time and money to develop new products to comply with term and rate filing requirements and to remain competitive in light of the long list of Maryland mandated benefits. Their efforts are being undercut by companies selling unapproved stop loss policies with attachment points in violation of Maryland rules. This results in unfair competition in the insurance market.

The Insurance Administration is mandated to protect the citizens of this State from the actions of unlicensed insurance carriers or the purchase of unapproved insurance products. The General Assembly has provided that Maryland citizens are entitled to certain mandated health benefits. When insurers undertake the subterfuge of categorizing an employer as self-insured, and thus exempt from the state's laws, yet provide an unapproved insurance product which acts as a replacement for direct insurance, consumers are denied the protections and benefits intended by the Maryland General Assembly.

III. The Regulation

In order to protect consumers, reduce unfair competition in the insurance market, and implement the public policies of the State, as expressed in H.B. 1359 and other provisions of the Insurance Code, I determined to formalize the MIA policy regarding stop loss insurance in regulation form. Determining the "correct" attachment points is not an exact science. In making my initial decision, I examined the actions of other states, the recommendation of the NAIC, the views of MIA staff, and the commentary of employers, insurers, and associations interested in the issue.

Recognizing that the establishment of specific and aggregate attachment points is an imperfect science, my staff undertook several months of research and review to determine whether the $25,000 and 125% levels set by guideline were most appropriate for Maryland. My staff conducted a survey of how stop loss policies were regulated in other states. The results of this survey indicated that, while many states regulate this coverage, only New Jersey

and New York enforced a specific attachment point at the same level as Maryland's. Although Maryland's highly urban population centers and high overall health care costs may justify its placement at the high end of the national average, nevertheless the MIA considered lowering its required specific attachment point.

In addition, the MIA closely followed the work of the National Association of Insurance Commissioners (NAIC). The NAIC drafted a Stop Loss Model Act in 1994 which was adopted by the NAIC Executive Committee in September 1995. Prior to the drafting stage, the NAIC commissioned an actuarial study by the firm Coopers & Lybrand. The ERISA Working Group of the NAIC initially developed a standard that when an employer passes on more than 50% of the risk of providing his employees' health care coverage to a stop loss carrier it has become a subterfuge for a health insurance policy. This standard was based on the premise that the lower the specific and aggregate attachment point is, the more risk is transferred from the plan to the stop loss carrier. A plan which transfers a large portion of its risk is not truly self-insured. The study itself undertook to analyze the transfer of risk from a self-insured benefit plan to a stop loss carrier. Based on the standard deviation method, the study calculated the percentage of self-insurance risk retained by the employer given several sample benefit packages. From the data produced in the study, the ERISA Working Group of the NAIC recommended a specific attachment point of $20,000 and an aggregate attachment point of 120% of expected claims.

I have reviewed the Coopers & Lybrand study, and believe that it is a professionally done and well reasoned report. I found it to be a reasonable and rational basis for selecting a $20,000 specific attachment point and think that

the NAIC was justified in recommending that point from an actuarial standpoint. Nothing I have heard or read since detracts at all from these conclusions.

Based on the regulatory guidance of the NAIC, the actuarial data on risk transfer, regulatory efforts of other states, the public, and my staff, I determined to require a specific attachment point of $20,000 rather than $25,000 and to retain an aggregate attachment point of 125% of expected paid claims.[1] These attachment points provide a reasonable basis for discriminating between health insurance and true stop loss insurance.

The regulation containing these attachment points was published in the Maryland Register in Volume 22, Issue 12 on June 9, 1995. The stated application was to all policies or contracts covering Maryland residents issued or renewed on or after January 1, 1996. Since the Administration had already received a great deal of input from a variety of sources prior to the publication of the regulation, it was determined that a public hearing was not necessary. However, comments were solicited until July 11, 1995. All comments received were considered. The regulation was published as a final regulation on August 24, 1995 and was effective 30 days later on September 24, 1995.[2]

---

[1] Very few concerns were raised regarding the setting of the aggregate attachment point at 125% of expected claims.

[2] On May 15, 1995 a suit was filed in the United States District Court for the District of Maryland against myself as Commissioner and the Insurance Administration by five plaintiffs including an insurer, a TPA, and 3 employers. The suit (continued...)

IV. The Public Hearing

Subsequent to the final adoption of the Maryland stop loss regulation, public interest in the regulation increased dramatically. This coincided with the vote by the NAIC Executive Committee to finally approve the Stop Loss Model Act in September 1995. In Maryland, opponents of the regulation voiced concern in three areas. First, a small minority argued that any attempt to regulate stop loss insurance is preempted by the Employee Retirement Income Security Act, commonly known as ERISA. 29 U.S.C. §1001 et seq. Second, a large majority argued that a $20,000 specific attachment point is too high. Third, some opponents argued that the aggregate attachment point of 125% of expected paid claims is too high, particularly for large groups. There were supporters as well, who agreed that the regulation is necessary and that the selected attachment points were appropriate and fair. Due to the number of persons who wished to be heard, I decided to hold a public hearing to determine whether to amend the attachment points in the stop loss regulation.

The public hearing was held on November 13, 1995. A number of exhibits were introduced including Maryland's stop loss regulation, the Stop Loss Model Act of the NAIC, the Coopers & Lybrand actuarial study for the NAIC,

---

(...continued)
challenges the MIA's authority to establish any attachment points based on ERISA preemption grounds. See American Medical Security, Inc., et al v. Insurance Commissioner & Administration, Civil No H 95-1463. No decision has been issued in this case.

minutes of the NAIC committees which considered the Model Act, and approximately 50 letters received by Associate Commissioner Reichel during the public comment period in June and July 1995. Eighteen witnesses testified. These witnesses represented a multitude of different opinions and backgrounds. Among the witnesses were 4 employers, 4 third party administrators, 6 insurers and several associations such as the Health Insurance Association of America. In addition to the oral testimony, I received a number of written documents on the 13th which were entered into the record. Among these documents were letters by various groups and a report by Blue Cross/Blue Shield of Maryland. At the close of oral testimony, I indicated that additional written submissions would be welcome until Friday, November 24, 1995. Additional submissions were received during this time.

The vast majority of all witnesses and commentators have expressed the view that some attachment point is appropriate. Nearly everyone agrees that at "low" attachment points, the policy in reality becomes a health insurance policy and not merely a catastrophic loss policy.[3] The only real disagreement concerns the meaning of "low". On this point, most witnesses testified that an attachment point of $10,000 or above was appropriate and would not be

---

[3] Even Roger Bayne from American Medical Security, a plaintiff in the pending litigation regarding the stop loss regulation, testified that a specific attachment point of $500 is "abusive", that $2000 is "absurd", that some regulation is necessary, and that a specific attachment point in the $5000-10,000 range is reasonable.

overly burdensome to small and medium size employers.[4]

Since the hearing I have reviewed all the evidence available to me. I have again reviewed the actuarial study of Coopers & Lybrand. I have reviewed the Milliman and Robertson study, the transcript of oral testimony, all written submissions from both before and after the hearing, and the recommendations of my staff. In considering whether to amend the regulation as currently adopted, I have used my best judgment and expertise to protect the interests of the citizens of Maryland and principles of fairness and equity in the market. As always, I have been guided by the Insurance Code and the laws of Maryland in determining this issue. I have concluded that the regulation should be amended to require a specific attachment point of $10,000 and an aggregate attachment point of 115% of expected claims.

---

[4] For example, Elizabeth Buck on behalf of the Prince George's Chamber of Commerce and Buck Distributing (having 100 employees) testified that $10,000 would be fair. William Gordon of Belfort Instrument Company (having 35 employees) has had specific attachment points of $10,000 and 12,500. Anita Wagner of Mason, Ketterman & Morgan (having 60 employees) has had specific attachment points of $7,500, $10,000, and $12,500. Dennis Mather of Mather & Morgan testified that groups using a specific attachment point below $10,000 are clearly not self-insured. Robert Erskine of Employee Security Inc. (a TPA), Dennis Fuller of Chesapeake Administrators (a TPA), and Robert Sacks of Denta-Check (an insurer) support $10,000.

V. Discussion

A number of issues have been raised regarding the stop loss regulation, including ERISA preemption, the size of the specific attachment point, the amount of the aggregate attachment point, whether the regulation applies to claims incurred or paid during the policy period, whether a stop loss policy can offer either an aggregate or a specific attachment point, and whether claims can be paid directly by the carrier. Each of these issues are discussed below.

(1) ERISA PREEMPTION

ERISA was intended to ease the administration of employee benefit plans for multi-state employers and to prevent the mismanagement of plan funds by requiring compliance with federal standards for reporting, disclosure, and fiduciary responsibility. To this end, ERISA preempts state laws which "relate to" an employee welfare benefit plan and which are not "saved" from preemption under the savings clause as laws which regulate the business of insurance. ERISA specifically requires that an employee welfare benefit plan may not be deemed to be an insurance company for purposes of bringing it within the scope of state regulation. While in many ways ERISA preemption is broad, it is not so broad as to prevent Maryland from regulating health insurance sales.

The stop loss regulation under review does not "relate to" an ERISA plan as required by 29 U.S.C. §1144(a). Preemption does not occur if the state law has only a "tenuous, remote, or peripheral connection with covered plans". Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983). Thus, state laws of general application which make no

reference to ERISA plans are not preempted. State laws have been preempted where they require an ERISA plan to provide mandated benefits, Shaw v. Delta Airlines, 463 U.S. at 95-100; prohibit plan provisions, Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523-26, (1981); or force a certain benefit structure, Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 10-11 (1987). Maryland's stop loss regulation does none of these things.

State laws that have a "connection" to ERISA plans require more than a mere burden or indirect cost on the administration of the plan to trigger preemption. The Supreme Court held in N.Y. State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co., 115 S.Ct. 1671 (1995) that New York's hospital surcharge system did not result in "such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers". Id. at 22. Indeed, "if ERISA is held to invalidate every State action that may increase the cost of operating employee benefit plans, those plans will be permitted a charmed existence that never was contemplated by Congress." Rebaldo v. Cuomo, 749 F.2d 133, 138-9 (2nd Cir. 1984), cert. denied, 472 U.S. 1008 (1985). The mere fact that a state law has some economic effect on an ERISA plan does not require that the law be invalidated.[5]

---

[5] While some opponents of Maryland's stop loss regulation have argued that compliance with the $20,000 specific attachment point would economically affect their employee benefit plans, this potential "indirect economic influence" is not sufficient to trigger preemption. A state law may have an "indirect economic influence" on an ERISA plan without relating

(continued...)

Even if a state law is found to "relate to" an employee benefit plan, this, by itself, is not fatal. ERISA provides an exception for state laws which regulate the business of insurance, referred to as the "savings clause". 29 U.S.C. § 1144(b)(2)(A). Maryland's regulation, which is directed solely at authorized insurance carriers in the state, regulates the insurance contract itself. It does not purport to, nor could it, regulate employer plans. The regulation merely delineates the difference between two types of insurance policies: stop loss policies and health insurance policies. The regulation in no way attempts to influence or regulate the underlying ERISA plan. The Insurance Administration is neither requiring a self-funded plan to purchase a fully insured health plan nor even encouraging them to do so. The stop loss regulation does not regulate the type of benefits that must be provided by ERISA plans nor does it create any reporting, disclosure, funding, or vesting requirements for the ERISA plan. The regulation merely defines the point below which the sale of "stop loss" insurance is, in fact, health insurance with a deductible rather than catastrophic loss coverage.

In summary, I am persuaded that the stop loss

(...continued)
to the plan in a way that constitutes regulation of the plan itself. The stop loss regulation does not bind plan administrators to any particular choice of benefit package or financing option. Indeed, it is entirely up to the self-funded plan to determine, as an individual business decision, what benefit package to offer, whether to purchase stop loss coverage, and, ultimately, whether to self-insure at all.

regulation, as currently drafted, is not preempted by ERISA. The regulation does not "relate to" an ERISA plan in that it has such an indirect impact on such a plan as to not constitute a connection with the plan. Moreover, even if the regulation is found to relate to an ERISA plan, it is saved from preemption because it regulates the business of insurance, a subject solely within the jurisdiction of the states to regulate.

(2) SPECIFIC ATTACHMENT POINT

As discussed above, I have carefully reviewed the actuarial study conducted by Jim Robinson of Coopers & Lybrand on behalf of the NAIC. I believe this report contains an excellent analysis of risk shifting where stop loss insurance is purchased. I continue to believe that this report would readily support a $20,000 specific attachment point. Nonetheless, I have considered other evidence, including the attachment points which are used in other states[6] and the testimony at the public hearing. One of the interested groups commissioned a study by the firm Milliman and Robertson. This study purported to provide an alternative analysis for selecting the appropriate attachment points. It appears to indicate that, for groups of 50 lives or more, the expected level of claims retained by an employer would equal those ceded to a stop loss carrier at a specific attachment point of $10,000. Thus, the actuarial

---

[6] Most of the states which regulate stop loss insurance require a $10,000 specific attachment point, including Missouri, Minnesota, Colorado, Kansas, Tennessee, Oregon, and Maine. Some states require a higher level; New York and New Jersey, for example, require a $25,000 specific attachment point.

evidence clearly supports an attachment point of at least $10,000. In my view, any amount below this minimum would not be true stop loss coverage and it may well be that a higher figure is appropriate.[7]

I also recognize that selecting an attachment point is not an exact science and requires the exercise of informed judgment. In exercising my regulatory judgment, I believe that a $10,000 specific attachment point is a reasonable compromise which will not be unduly burdensome to employer groups, but at the same time will carry out the basic public policies of the State as expressed by the General Assembly in the Insurance Code. As with any regulation, this attachment point will be subject to modification at some future date in the event that it is shown to have been too low in actual practice.

(3) AGGREGATE ATTACHMENT POINT

In the current regulation, the aggregate attachment point is 125% of expected claims. The NAIC Model Act set the figures at 120% of expected claims for small employers and

---

[7] Arthur Wilmes, a consulting actuary with the firm Milliman and Robertson and author of the study reviewing the 1994 Coopers & Lybrand report testified at the public hearing. He was questioned by the MIA's Chief Actuary and myself on the soundness and relevance of his study. I am convinced that both studies are actuarially sound. The Coopers & Lybrand study represents a stricter standard of risk transfer, while the Milliman and Robertson study represents a less strict measure for risk transfer. Both studies are useful to a regulator in choosing appropriate attachment points.

110% for large employers. Several individuals testified at the hearing that 125% or even 120% were too high, especially for large groups.

My actuarial expertise convinces me that for large groups, a figure in excess of 115% of expected claims is unwarranted. Several witnesses suggested that a sliding scale of attachment points based on the size of the group would be preferable. I have determined, however, that such a method would be impractical from a regulatory standpoint and believe it is incumbent on me to select the most reasonable and effective attachment point for stop loss policies generally. Accordingly, I have concluded that 115% is an appropriate figure for an aggregate attachment point and will be applicable to groups of any size.

(4)- "CLAIMS INCURRED" VERSUS "CLAIMS PAID"

The regulation states that the aggregate attachment point minimum is 125% of expected paid claims. Richard Gorenflo of MAMSI raised an issue regarding this language. He noted that claims which are incurred but not paid during a policy period result in a "tail" of liability which does not become apparent until after the policy period ends. The regulation is not intended to create a situation where tail liability may impact a policyholder. Accordingly, we have amended the regulation to define "expected claims" as those claims projected to be incurred by a plan in a given benefit year. The aggregate attachment point will therefore be calculated by applying 115% to those expected incurred claims.

(5) "AND" VERSUS "OR"

The regulation as drafted reads in .03(B)(3) and (4), "The specific attachment point ... is at least $20,000 per employee, dependent, member, or participant per year; and (4) The aggregate attachment point ... is, at a minimum, 125 percent of expected paid claims...". There appears to be some confusion on the part of the public as to whether this language requires a stop loss policy to provide both a specific and an aggregate attachment point in every policy or simply that a policy containing either must comply with the required minimum attachment point applicable to it. I have therefore amended the language of the regulation to read "if the policy contains a specific attachment point, the specific attachment point shall be at least $10,000..." and "if the policy contains an aggregate attachment point, the aggregate attachment point shall be 115 percent of expected claims..." to clarify that a stop loss policy need not contain both a specific and an aggregate attachment point, but either attachment point it does contain must meet the minimum requirement. This result is in accordance with the NAIC Model Act, industry practice, and sound actuarial assumptions.

(6) STOP LOSS CARRIER REIMBURSING THE EMPLOYER RATHER THAN THE PROVIDER

The regulation currently requires that the stop loss carrier make payments only to the plan, its sponsor or the administrator of the plan and not to either the employees or providers directly. See .03(B)(2) Blue Cross and Blue Shield has asserted that this requirement would create administrative and contractual difficulties in that it frequently reimburses providers directly under the terms of

its administrative service agreements. The regulation is not intended to prohibit an insurance carrier from functioning both as an administrator and as a stop loss insurer, provided respective contractual liabilities are clear. I have determined to amend this language to clarify that a carrier is liable for payment only to the plan itself and not to plan beneficiaries or providers, regardless of whether a carrier, in its capacity as administrator of the plan, actually makes the payments.

The purpose of the regulation is to define what is true stop loss coverage. Such coverage reimburses a plan for claims above the attachment point. Thus carriers will be required to exercise care to ensure that their administrative functions are consistent with their contractual liability. This result is required by the regulation's purpose of clearly differentiating these two types of policies.

CONCLUSION

For all the above reasons, I have determined that the stop loss regulation COMAR 09.31.02 shall be amended to reflect a minimum specific attachment point of $10,000 and a minimum aggregate attachment point of 115% of expected incurred claims, either of which will be sufficient to approve a policy of stop loss insurance. I will propose that this amended regulation be promulgated on an emergency basis.

So ORDERED this 8th of December, 1995.

Dwight K. Bartlett, III
Maryland Insurance Commissioner

CODE OF MARYLAND REGULATIONS

09.31.02

Subtitle 31 MARYLAND INSURANCE ADMINISTRATION

Chapter 02 Health Insurance--Stop-Loss Coverage

Authority: Article 48A §§ 26, 66, and 213, Annotated Code of Maryland

.01 Scope.

These regulations apply to all policies or contracts covering Maryland residents which are issued or renewed on or after January 1, 1996.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Aggregate attachment point" means the dollar amount per plan beyond which the carrier issuing the stop-loss health insurance coverage assumes some or all of the plan's liability for payment of covered services or benefits.

(2) "Carrier" means:

(a) An insurer that holds a certificate of authority in the State and provides or is authorized to

provide health insurance in the State; or

(b) A nonprofit health service plan that is authorized to operate in the State and provides or is authorized to provide health insurance in the State.

(3) "Expected claims" means the amount of claims that, in the absence of a stop-loss policy or other insurance, are projected to be incurred by a plan.

(4) "Plan" means employer-sponsored group health insurance coverage.

(5) "Specific attachment point" means the dollar amount per employee, dependent, member, subscriber, or participant, per year beyond which the carrier issuing the stop-loss health insurance coverage assumes some or all of the plan's liability for payment of covered services or benefits.

(6) "Stop-loss health insurance coverage" means a policy, contract endorsement, attachments, amendments, or other modifications to that contract, issued to an employer, or a trustee or association acting on behalf of that employer, to insure against losses of an employer's health plan.

.03 Coverage.

A. A policy or contract issued to an employer which insures against losses or claims resulting from the bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, or childbirth, or against expenses incurred in prevention of sickness, or dental care,

of the employees of that employer is considered to be a policy or contract of health insurance.

B. A policy or contract issued to an employer may be considered to be a policy or contract of stop-loss health insurance coverage only if:

(1) The stop-loss coverage is issued to and insures the sponsor or administrator of the plan or the plan itself and is not issued to employees, dependents, members, or participants;

(2) The carrier is liable for payments only to the sponsor or administrator of the plan or the plan itself and not to the employees, dependents, members, subscribers, participants, or providers;

(3) If the policy contains a specific attachment point, the specific attachment point shall be at least $10,000 per employee, dependent, member, subscriber or participant per year; and

(4) If the policy contains an aggregate attachment point, the aggregate attachment point shall be, at a minimum, 115 percent of expected claims for all employees, dependents, members, subscribers or participants.

.04 Taxes.

Premiums attributable to stop-loss health insurance coverage shall be allocated and taxes computed in accordance with Article 48A, Subtitle 47, Annotated Code of Maryland.

.05 Required Provisions.

An insurer issuing a stop-loss health insurance policy shall offer the applicant for the policy the option to purchase a policy that provides that if a claim begins while the stop-loss health insurance policy is in effect, the carrier shall continue to pay benefits for the continuance of the claim after the stop-loss health insurance coverage terminates, until the earlier of:

A. The date the claim terminates; or

B. 90 days from the termination of the stop-loss health insurance policy.

29 U.S.C.A. § 1144

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Supreme Court, U.S.
FILED
OCT 2 1997
CLERK

(2)

No. 97-218

In The

Supreme Court of the United States

October Term, 1996

STEVEN B. LARSEN, IN HIS CAPACITY AS INSURANCE COMMISSIONER OF THE STATE OF MARYLAND,

Petitioner,

v.

AMERICAN MEDICAL SECURITY, INC., *et al.*,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

AMICUS CURIAE BRIEF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS IN SUPPORT OF PETITIONER

GREGORY B. STITES
Counsel of Record
for Amicus Curiae,
National Association of
Insurance Commissioners
120 W. 12th Street, Suite 1100
Kansas City, Missouri 64105
(816) 842-3600

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

23PP

TABLE OF CONTENTS

Page

INTEREST OF THE NAIC 1

SUMMARY OF ARGUMENT 6

ARGUMENT 8

INTRODUCTION 8

I. THE COURT OF APPEALS' CONSTRUCTION OF 29 U.S.C. § 1144(A) IS INCONSISTENT WITH THE PRESUMPTION AGAINST PRE-EMPTION OF TRADITIONAL STATE POLICE POWERS 9

II. THE DECISION BELOW CONFLICTS WITH THIS COURT'S ERISA DECISIONS 12

III. THE DECISION BELOW CONFLICTS WITH DECISIONS OF OTHER COURTS OF APPEALS 14

IV. LAWS REGULATING THE BUSINESS OF INSURANCE ARE SAVED FROM PRE-EMPTION 15

CONCLUSION 18

TABLE OF AUTHORITIES

Page

CASES:

Alessi v. Raybestos Manhatton, Inc., 451 U.S. 504 (1981) 10

California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., 117 S. Ct. 832 (1997) 10

DeBuono v. NYSA-ILA Medical and Clinical Services Fund, 117 S. Ct. 1747 (1997) 6

District of Columbia v. Greater Washington Board of Trade, 506 U.S. 125 (1992) 10

FMC Corp. v. Holliday, 498 U.S. 52 (1990) .. 7, 12, 13, 17

Gonzales v. Prudential Ins. Co. of America, 901 F.2d 446 (5th Cir. 1990) 7, 14, 15

Hillsborough County v. Automated Medical Laboratories, Inc., 471 U.S. 707 (1985) 6

Jones v. Rath Packing Co., 430 U.S. 519 (1977) 6

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) ..... *passim*

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995) ..... *passim*

Securities and Exchange Commission v. National Securities, Inc., 393 U.S. 453 (1969) 7, 14

U.S. Dept. of the Treasury v. Fabe, 508 U.S. 491 (1993) 14

TABLE OF AUTHORITIES – Continued

Page

STATUTES:

15 U.S.C. § 1011 2

29 U.S.C. § 1001 3

§ 1002(1) 7, 16, 17, 18

§ 1144(a) 6, 9

§ 1144(b)(2)(A) 9, 17

§ 1144(b)(2)(B) 7, 9, 14, 17

OTHER AUTHORITIES:

Couch on Insurance 3d 1:4 12

NAIC Model Laws, Regulations and Guidelines VOL. I, p. 92, "NAIC Stop-Loss Model Act" (October 1995) 2

INTEREST OF THE NAIC

The National Association of Insurance Commissioners (NAIC) is a non-profit, unincorporated association established in 1871, whose membership consists of the principal insurance regulatory officials of the 50 States, the District of Columbia, the territories and insular possessions of the United States.

In submitting this *amicus curiae* brief, the NAIC seeks to demonstrate its interest in this proceeding and to fulfill the mission of the NAIC, as set out in its Constitution, to:

> . . . assist state insurance regulators, individually and collectively, in serving the public interest in achieving the following fundamental insurance regulatory goals in a responsive, efficient and cost-effective manner, consistent with the wishes of its members:
>
> 1. Protect the public interest, promote competitive markets and facilitate the fair and equitable treatment of insurance consumers;
> 2. Promote the reliability, solvency, and financial solidity of insurance institutions; and
> 3. Support and improve State regulation of insurance.

The interest of the NAIC arises out of the regulatory responsibility vested in each insurance regulator [hereinafter commissioner] to see that all laws respecting

---

**Amicus* states pursuant to Rule 37.6 that no counsel for a party authored this brief in whole or in part and no person or entity, other than the *amicus curiae*, its members, or its counsel, made a monetary contribution to the preparation or submission of this brief.

insurance companies and the types of policies offered for sale in his or her State are executed faithfully. The commissioners of the various States are charged with the responsibility of regulating the business of insurance within their jurisdictions pursuant to the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.*, and State insurance laws.

One of the most important activities conducted by the members of the NAIC is the development and drafting of model statutes and regulations to address common problems nationwide. These models are intended to serve only as guideposts for members when presenting proposed insurance legislation in various State legislatures and in adopting appropriate regulations for more efficient and effective regulation of insurance in the States.

For the same underlying marketplace abuses identified by the Petitioner (Pet. Brief 8-10), the members of the NAIC drafted a model substantially similar to the Maryland regulation that is the subject of this case. *See, NAIC Model Laws, Regulations and Guidelines,* VOL. I, p. 92, "NAIC Stop-Loss Model Act" (October 1995).

The NAIC Stop-Loss Model Act establishes criteria to determine whether a policy submitted to a commissioner for approval prior to sale and denominated as a stop-loss insurance policy by the insurer is, in reality, performing in substantially the same way as a health insurance policy and thus should be subject to State laws regulating health insurance. The purpose of the NAIC model is to establish a fair and reasonable actuarial standard for the determination of whether the risk transfer agreement (the policy) should be treated as a health insurance policy or

as a stop-loss insurance policy for purposes of State regulation of insurance. Generally, the actuarial standards in the NAIC model require that insurers that sell stop-loss insurance cannot assume more than 50% of the risk of loss for the covered medical expenses of employees. If insurers assume more than 50% of the risk, insurers must re-file the policy form under the State's laws regulating health insurance policies. The Maryland regulation in this case parallels the NAIC model but permits insurers to assume an even higher proportion of the employer's risk of loss for medical expense claims and still have the policy form approved as a stop-loss insurance product.

Neither the Maryland regulation nor the NAIC model imposes any obligations on employee welfare benefit plans established under the Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1001, *et seq*. Commissioners have a special responsibility to assist their States in controlling health care costs and in expanding access to health insurance. Since the Federal government appears to have abandoned its efforts to craft a comprehensive health-care plan, it is imperative that States, through their commissioners, remain free to correct abuses in the health care marketplace. The regulation in question establishes a "bright-line" definition that draws a rational distinction between two types of insurance policies. The line is actuarially based on the amount of risk the policy shifts to the insurer so as to distinguish true stop-loss insurance, which covers only catastrophic losses, from policies that are captioned as stop-loss, but that transfer substantial responsibility to the insurer for funding the covered medical expenses of an employee welfare benefit plan.

Preserving the traditional authority of the States to draw the legal distinctions between different types of insurance policies does not hinder the overall goals of ERISA, but rather supports them. The United States Congress enacted ERISA to provide effective protection for plan participants, and recognized that the States had the expertise needed to regulate the insurance policies that employee welfare benefit plans purchase. Accordingly, ERISA's "savings clause" expressly excludes state laws regulating insurance from pre-emption, even when those laws relate to employee welfare benefit plans. The McCarran-Ferguson Act delegates to the States the exclusive authority to regulate the business of insurance. States are free to permit or not to permit the types of insurance products offered for sale within their jurisdiction.

The court of appeals' decision below gives a new and unintended meaning to this Court's *dicta* in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985) which stated: "We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." That distinction flowed directly from the States' reserved authority to regulate insurance, and was not intended as a limitation on that authority.

The court of appeals used this language to draw an impermissible distinction between employee benefit plans that purchase one type of insurance policy to cover their loss exposure and those that purchase a different type of insurance policy. ERISA contains no authority for

that distinction. The distinction this Court drew in *Metropolitan Life* was not between the types of insurance policies purchased by plans, but "between insured and uninsured plans." The term "insured plan" has a simple and straightforward meaning in this context: a plan that purchases an insurance policy. To the extent that a plan choosing to buy a particular insurance policy is affected by state regulation of that policy, it is a permissible "indirect regulation" of that insured plan within the meaning of *Metropolitan Life*. This Court expressly stated in *Metropolitan Life* at 746-47:

> We therefore decline to impose any limitation on the "savings clause" beyond those Congress imposed in the clause itself and in the "deemer clause" which modifies it. *If a State law "regulates insurance," as mandated-benefit [in this case, stop-loss] laws do, it is not preempted.* Nothing in the language, structure, or legislative history of the Act supports a more narrow reading of the clause, *whether it be the . . . attempt to save only state regulations unrelated to the substantive provisions of ERISA*, or the insurers' more speculative attempt to read the "savings clause" out of the statute (emphasis added).

The NAIC encourages the Court to reverse the decision of the Fourth Circuit so that the substantive terms, benefits and types of insurance policies offered for sale in the marketplace will remain fully within the regulatory scope of authority of the individual States. This is consistent with statutory law and common law and is in the

best interest of insurance consumers, whom commissioners are charged by both State and Federal law to protect.[1]

SUMMARY OF ARGUMENT

1. Section 1144(a) of ERISA expressly preempts State laws that "relate to any employee welfare benefit plan." 29 U.S.C. § 1144(a). However, the court of appeals' decision extends the preemptive effect of 29 U.S.C. § 1144(a) far beyond the bounds intended by Congress. The court of appeals failed to construe the express preemptive language of 29 U.S.C. § 1144(a) in light of the presumption against pre-emption. This Court has always analyzed ERISA pre-emption cases on the assumption that the historic police powers of the States were not to be superseded unless that was the clear and manifest purpose of Congress. *See, Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977). The Court has also noted that the historic police powers of the State include the regulation of matters of health and safety. *See, DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 117 S. Ct. 1747, 1752 (1997) (quoting *Hillsborough County v. Automated Medical Laboratories, Inc.*, 471 U.S. 707, 715 (1985)). When read in connection with this Court's earlier cases, the court of appeals failed to give proper weight to this Court's decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995). The court of appeals failed to use the proper standard when it determined that

[1] The parties have consented to the filing of this *amicus curiae* brief. Stipulations indicating their consent have been filed with the Clerk of the Court.

the Maryland regulation "relates to" an employee welfare benefit plan.

2. The court of appeals erroneously concluded that the Maryland regulation "deemed" ERISA plans to be an insurance company within the meaning of ERISA's "deemer clause." 29 U.S.C. § 1144(b)(2)(B).

The court of appeals also implied that the Maryland regulation did not regulate the business of insurance, in direct conflict with previous decision of this Court. *Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453, 460 (1969).

3. The court of appeals' extravagant reading of the "deemer clause," 29 U.S.C. § 1144(b)(2)(B), conflicts with the better-reasoned Fifth Circuit case of *Gonzales v. Prudential Ins. Co. of America*, 901 F.2d 446, 453-54 (5th Cir. 1990).

4. The NAIC requests this Court to accept *certiorari* and hold that all State laws regulating the business of insurance that only indirectly affect an employee welfare benefit plan are "saved" from pre-emption. This would create a safe-harbor rule from ERISA pre-emption for all State laws regulating the business of insurance.

The NAIC requests this Court to adopt the interpretation of the "deemer clause," 29 U.S.C. § 1144(b)(2)(B), that was urged by Justice Stevens in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990). ERISA plans provide benefits "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1). ERISA does not preempt a State's right to regulate the relationship between an

insurer and insured or control the design of insurance policies.

ARGUMENT

INTRODUCTION

The NAIC is vitally concerned that insurers not be allowed to charge into the regulatory gap created by the court of appeals' decision. Pet. App. 14a. The decision below permits insurers to circumvent the State of Maryland's right under Federal law to regulate and control the relationship between an insurer and an insured and the type of policies permitted to be sold in its marketplace. Maryland has enacted needed health-care reforms, including certain health insurance statutes, in the best interests of its citizens. The court of appeals' decision permits insurers to subvert and avoid Maryland's health insurance laws and engage in a scheme of deception that exploits form over substance. If left to stand, the decision allows health insurers to merely caption a policy as stop-loss insurance and escape any further regulation by the State.

The commissioner's promulgation of the regulation was simply an attempt to provide a "bright-line" definition between permitted types of stop-loss policies and health insurance policies sold in Maryland. The reason to establish a bright-line is to give guidance to insurers when designing policies for submission and approval by the commissioner, as required by Maryland law.

I. THE COURT OF APPEALS' CONSTRUCTION OF 29 U.S.C. § 1144(a) IS INCONSISTENT WITH THE PRESUMPTION AGAINST PRE-EMPTION OF TRADITIONAL STATE POLICE POWERS.

Three provisions of ERISA speak to the question of pre-emption. These include: 1) the "pre-emption clause," which states that the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter 'relate to' any employee [welfare] benefit plan," except as provided in the "savings clause" 29 U.S.C. § 1144(a); 2) the "savings clause," which states that "except as provided in the deemer clause, nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities" 29 U.S.C. § 1144(b)(2)(A); and, 3) the "deemer clause," which states that:

> Neither an employee benefit plan . . . nor any trust established under such a plan shall be deemed to be an insurance company, or other insurer . . . or to be engaged in the business of insurance . . . for the purposes of any law of any State purporting to regulate insurance companies, insurance contracts . . .

29 U.S.C. § 1144(b)(2)(B).

In 1995, this Court sent a message for heightened judicial restraint when determining whether State laws were pre-empted by ERISA. In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), the Court, in a unanimous decision, clarified the outer reaches of the first prong of the ERISA pre-emption test, whether a State law impermissibly "relates to" an employee welfare benefit plan within the meaning

of the ERISA pre-emption clause. The court of appeals below made no reference to *Travelers* and chose instead to rely on *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992); and *Alessi v. Raybestos Manhattan, Inc.*, 451 U.S. 504 (1981).[2] However, these cases can be distinguished because the State law in question, whether found after analysis to "relate to" or not, would have applied directly to all employee welfare benefit plans. In the matter before this Court, Maryland's regulation applies only to insurers, and would only indirectly affect employee welfare benefit plans that voluntarily choose to purchase a certain type of insurance in the State. The court of appeals erroneously concluded that since the regulation referenced ERISA plans, it "relates to" ERISA plans. Pet. App. 10a. Maryland's regulation only made reference to employee welfare benefit plans for the purpose of explaining why aberrant insurer conduct in the marketplace needed adjustment by clarifying regulation. The court of appeals correctly found that the "regulations [in this case] are carefully drafted to focus directly on insurance companies issuing stop-loss insurance and not on the employee benefit plans themselves." Pet. App. 11a. However, having so held, the court of appeals then failed to apply this Court's standard that "laws that regulate only the insurer, or the way in which it may sell insurance, *do not relate to benefit plans.*" *Travelers* at 663 (emphasis added).

---

[2] The court of appeals also cited to *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A.*, 117 S. Ct. 832 (1997). However, the court of appeals failed to analyze this case consistent with this Court's methodology in *Dillingham*, which was first articulated in *Travelers*.

The court of appeals should have started by analyzing the "relates to" question using the analysis used by this Court in *Travelers*. A "relates to" analysis should be done regardless of whether the State law in question appears at first reading to regulate insurance. "The basic thrust of the pre-emption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Travelers* at 657. The Maryland regulation leaves employee welfare benefit plans free to establish their own benefit structures and administration. However, after investigating the types of insurance policies in the marketplace, some plans may decide it is more favorable for them to purchase a policy to provide benefits to their participants as opposed to designing their own unique benefit structure and self-funding the risk associated with it. The regulation affects plans that voluntarily choose to purchase a policy, thus it only indirectly influences some plans. The regulation does not bind all plan administrators to any particular choice of benefit structures or administration. The influence only affects a plan's "shopping decisions." *Travelers* at 660. Maryland's regulations "leave plan administrators right where they would be in any case, with the responsibility to choose the best overall coverage for the money." *Travelers* at 662.

Applying the analysis of *Travelers*, the NAIC urges the Court to find that the regulation does not "relate to" employee welfare benefit plans.

II. THE DECISION BELOW CONFLICTS WITH THIS COURT'S ERISA DECISIONS.

The NAIC adopts the Petitioner's arguments that the court of appeals' decision below conflicts with the Court's ERISA decisions. The court of appeals erred by holding that the Maryland regulation "violates the ERISA provision that no ERISA plan 'shall be deemed to be an insurance company . . . for purposes of any law of any State purporting to regulate contracts.' " Pet. App. 12a. As briefed by Petitioner, the holding conflicts with this Court's earlier decisions. The court of appeals erred by drawing a distinction between self-funded plans and insured plans that is contrary to the one this Court drew in *Metropolitan Life* and in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990). In *FMC* at 54, the Court distinguished between these types of plans by explaining that a "self-funded" plan is one that does not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants.[3] The court of appeals misreads this to craft an impermissible distinction between policies sold to employers (or employee welfare benefit plans) in

---

[3] A leading treatise on insurance law defines a "self-insurer" as follows: "Strictly speaking, this is an entity which, rather than purchasing insurance, undertakes to guard against its own risks by assessing the risks and establishing sufficient reserves to pay any losses which occurs. In practice, the term self-insured tends to be applied to any party who does not possess insurance, regardless of whether formal risk assessment has occurred or reserves were established. In the latter usage, there is no difference between a party who is uninsured, and one who is self-insured, while in the former usage, a self-insurer is very different from one who is uninsured." *Couch on Insurance 3d 1:4.*

the form of stop-loss insurance and policies sold to employers where plan participants have an express contractual right to benefits. The court of appeals then labels the former a "self-funded" plan and the latter an insured plan. Pet. App. 7a. ERISA contains no such distinction. An ERISA plan that chooses to purchase any type of insurance policy to satisfy its obligations is an insured plan, and State law may indirectly regulate such an ERISA plan through regulation of its insurer and its insurer's insurance contracts. *FMC* at 64.

The court of appeals' decision also implied that the Maryland regulation failed the third test set forth in *Metropolitan Life* for analyzing whether a law regulates the business of insurance – is the law's reach limited to entities within the insurance industry? – because they "interfere with the relationship between ERISA plans and their participants." Pet. App. 11a. The court of appeals' analysis misses the central point of *Metropolitan Life*, which is that a law that directly regulates only the insurer-insured relationship does *not* cease to be a "law regulating insurance" merely because it is also intended to have an indirect effect on other relationships. The regulation does not "interfere" with the plan-participant relationship in any manner other than the manner this Court expressly endorsed in *Metropolitan Life*. This Court has repeatedly held that the:

> relationship between an insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement – these were at the core of the "business of insurance. . . . " Statutes aimed at protecting or

> regulating this relationship, directly or indirectly, are the laws regulating the "business of insurance."

Securities and Exchange Commission v. National Securities, Inc., 393 U.S. 453, 460 (1969). *See*, also, *U.S. Dept. of the Treasury v. Fabe*, 508 U.S. 491, 501 (1993) (statutes aimed at regulating the relationship between an insurer and its insured, directly or indirectly, are laws regulating the business of insurance).

ERISA expressly saves all laws regulating the business of insurance, whether the type of policy permitted for sale in the marketplace is issued to an employer, an employee welfare benefit plan, or to plan participants.

III. THE DECISION BELOW CONFLICTS WITH DECISIONS OF OTHER COURTS OF APPEALS.

The NAIC adopts Petitioner's arguments that the court of appeals' extravagant reading of the "deemer clause," 29 U.S.C. § 1144(b)(2)(B), conflicts with decisions of other courts of appeals. In *Gonzales v. Prudential Ins. Co. of America*, 901 F.2d 446, 453-454 (5th Cir. 1990) ("deemer clause" prevented application of disability insurance law directly related to an ERISA plan), the court concluded that:

> Nothing in the "deemer clause" prohibits the application of State insurance laws to an insurer of an ERISA plan or to an insurance policy issued by such an insurer. Thus, by regulating the insurer or the insurer's policy, the State may without running afoul of the "deemer clause", "indirectly" influence the content and operation of an insured ERISA plan. However, the State

> may not accomplish this end directly; that is, it may not apply and enforce its insurance laws in such a way that an ERISA plan, as opposed to the insurer of the plan must conform to them or will face liability for failure to conform to them (footnote omitted).

The decision in *Gonzales* cannot be reconciled with the decision of the court of appeals below. The Fifth Circuit clearly articulated that States may regulate an insurer's policies sold to ERISA plans without running afoul of the "deemer clause" even though the regulation indirectly affects an ERISA plan. The court of appeals' decision conflicts with *Gonzales* by holding that even though Maryland's "regulations are carefully drafted to focus directly on insurance companies issuing stop-loss insurance, and not on the employee benefit plans themselves," Pet. App. 11a, those laws violate the "ERISA provision that no ERISA plan 'shall be deemed to be an insurance company. . . . ' " Pet. App. 12a. The court of appeals' decision conflicts with the Fifth Circuit, which correctly applied this Court's decision in *Metropolitan Life*.

IV. LAWS REGULATING THE BUSINESS OF INSURANCE ARE SAVED FROM PRE-EMPTION.

The NAIC urges the Court to expand its discussion in *Travelers* regarding *Metropolitan Life*. In *Travelers*, the Court opines on one hand that mandated coverage laws bear indirectly and substantially on all insured benefit plans, but on the other that laws regulating only the insurer, or the way in which it may sell insurance, do not relate to benefit plans. The Court went on to recognize

that not all regulations influencing cost would "relate to" employee welfare benefit plans within the meaning of ERISA pre-emption. *Travelers* at 663.

This means that before applying the "savings clause," courts should always apply a "relates to" analysis to State laws, even if they appear, on their face, to be laws regulating the business of insurance. Not all laws regulating the business of insurance will "relate to" employee welfare benefit plan structures or their administration. *Travelers* at 663-64. If the "relates to" analysis concludes that it is such a law, then the court must next determine whether it is a law that regulates the business of insurance. As this Court found in *Metropolitan Life*, if the insurance law bears indirectly, but substantially, on an employee welfare benefit plan because the plan purchased a policy of insurance to directly pay for or to reimburse for benefits to "employees in the event of sickness, accident, disability, death or unemployment," 29 U.S.C. § 1002(1), then the law is "saved" from pre-emption. In effect, the Court holds that all State laws regulating the business of insurance, by definition, affect employee welfare benefit plans only indirectly, and are therefore, "saved" from pre-emption. In this context, "indirectly" means that the:

> . . . focus [of the statutory term] was – it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance."

S.E.C. at 460.

Under the ERISA statute, employers may establish and maintain an "employee welfare benefit plan." These

plans offer a variety of medical, surgical, hospital and other benefits to employees in the event of sickness, accident, disability, death or unemployment. Employers may provide these benefits *through the purchase of insurance or otherwise.* 29 U.S.C. § 1002(1). ERISA makes no distinction between the types of insurance an employer (or employee welfare benefit plan) may purchase, clearly leaving the States in control of what policies may be offered for sale in the marketplace by insurers. An expansion of the discussion in *Travelers* would provide a common-sense meaning to ERISA's "savings clause." 29 U.S.C. § 1144(b)(2)(A). Congress intended to create a safe harbor from ERISA pre-emption for all State laws regulating the business of insurance, whether those laws substantially affect "insured" ERISA plans or not.

This approach would also provide a basis for a coherent interpretation of the "deemer clause," 29 U.S.C. § 1144(b)(2)(B). The "deemer clause" should act as the bright-line between ERISA plans and State laws that are unquestionably directly aimed at employee welfare benefit plans, as urged by Justice Stevens. *FMC* at 68-69. The "deemer clause" was necessary in order to prevent States from abusing their reserved authority to regulate insurance by forcing self-funded employee welfare benefit plans to seek authority as licensed insurance companies. Employee welfare benefit plan activities operate just like those of an accident and health insurance company: benefit schedules are designed, conditions of coverage are written, actuarial calculations of anticipated costs are estimated, administrative procedures are set up to pay claims, premium schedules are established (increasingly with higher percentages coming directly from employees)

and agents are hired to explain the differences in plan benefits to participants. Collecting premiums from people (employees) in exchange for promising them reimbursement for contingent amounts of medical expenses under a defined benefit schedule is the business of insurance. Without licensure as an insurer, these activities would be illegal under State unauthorized insurance laws, and therefore the "deemer clause" was enacted to give meaning to the Congressional intent to exempt these plans from direct State regulation.

However, ERISA plans may provide benefits "through the purchase of insurance or otherwise," 29 U.S.C. § 1002(1), and the "deemer clause" was never intended to apply to the insurance policies that the plans might purchase. When plans decide it is a better deal to purchase insurance, as opposed to self-funding their obligations, they should be required to do so just like any other purchaser in the marketplace. As this Court made clear in *Metropolitan Life*, ERISA does not preempt a State's right to regulate the relationship between an insurer and insured or control the design of policies.

CONCLUSION

The implications raised by the issues in this case are far-reaching. The pre-emption of State laws permitted by the decision of the court of appeals will be felt around the nation. It is typical that when a stop-loss policy is sold to an employee welfare benefit plan, the only State to have reviewed the design of the policy is the State that

approved the policy form, regardless of where plan participants covered by the policy may reside. Employees covered under such a policy may be living in any of the NAIC member States. As more and more employers come to the Fourth Circuit to take advantage of the pre-emption created by the court of appeals, the effect on employees living elsewhere will grow. Employees today, who perhaps have health insurance policies conforming to North Dakota law, may soon find their policies redesigned by an employer who locates its ERISA plan in Maryland in order to purchase an unregulated stop-loss policy. The court of appeals erroneously states that Congress has created this regulatory gap and that only Congress can close it. Pet. App. 14a. The NAIC respectfully requests that the Court grant the Petitioner's *Petition for a Writ of Certiorari*. A decision on the merits would fill the regulatory gap created by the court of appeals and reaffirm that regulation of the business of insurance is reserved exclusively to the States.

Respectfully submitted,

GREGORY B. STITES
National Association of
Insurance Commissioners
120 W. 12th Street, Ste. 1100
Kansas City, Missouri 64105
(816) 842-3600

Supreme Court, U.S.
FILED
OCT 6 1997
CLERK

(3)

No. 97-218

In The

Supreme Court of the United States

October Term, 1996

STEVEN B. LARSEN, in his capacity as Insurance Commissioner of the State of Maryland,

Petitioner,

vs.

AMERICAN MEDICAL SECURITY, INC., *et al.*,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

ANDREW JAY GRAHAM
KATHLEEN A. BIRRANE
KRAMON & GRAHAM, P.A.
One South Street
Suite 2600
Baltimore, Maryland 21202
(410) 752-6030

EDWARD J. BIRRANE, JR.
Counsel of Record
CYNTHIA M. DIETZ
EDWARD J. BIRRANE, JR. Chartered
28 West Allegheny Avenue
Suite 606
Towson, Maryland 21204
(410) 823-0464

Attorneys for Respondents

72169 (800) 3 APPEAL • (800) 5 APPEAL • (800) BRIEF 21 Lutz Appellate Services, inc.

29 pp

QUESTIONS PRESENTED

1. Whether the Court of Appeals for the Fourth Circuit was correct in determining that the Employee Retirement Income Security Act of 1974 ("ERISA") preempts a Maryland insurance regulation that forces self-funded ERISA plans that purchase certain levels of stop-loss reinsurance to provide state-mandated health benefits to plan participants.

2. Whether the purchase of stop-loss insurance by an ERISA plan converts a self-funded plan not subject to state regulation into a fully insured plan subject to indirect state regulation.

3. Whether a state law that purports to regulate insurance, but is intended to prevent small employers from forming or maintaining self-funding ERISA plans by eliminating their ability to purchase stop-loss insurance, is preempted by ERISA because: (a) the law is not directed at the business of insurance and, thus, is not saved from preemption; (b) the law is directed at ERISA plans and, thus, cannot be enforced by virtue of the deemer clause; or (c) the law forces ERISA plans to adopt a state-mandated scheme of substantive benefits or risk insolvency.

PARTIES TO THE PROCEEDING

The petition accurately lists the parties to the proceeding.

The parent company of respondent American Medical Security, Incorporated is American Medical Security Group, Incorporated. American Medical Security, Incorporated has no nonwholly owned subsidiaries.

The parent company of respondent United Wisconsin Life Insurance Company is United Wisconsin Services, Incorporated, a publicly held corporation. United Wisconsin Life Insurance Company has no nonwholly owned subsidiaries.

Respondents Client First Brokerage Services, Incorporated; Maran, Incorporated; and Trio Metal Products Company, Incorporated have neither parent companies nor nonwholly owned subsidiaries.

TABLE OF CONTENTS

	Page
Questions Presented	i
Parties to the Proceeding	ii
Table of Contents	iii
Table of Citations	iii
Statement of the Case	1
Reasons for Granting the Writ	10
I. This Case Presents An Important Question Of Federal Law Which Has Not Been, But Should Be, Addressed By This Court.	12
II. There Is A Body Of Commentary That Perceives An Irreconcilable Split Among The Circuit Courts.	17
Conclusion	22

TABLE OF CITATIONS

Cases Cited:

Associated Industs. of Missouri v. Angoff, 937 S.W. 2d 277 (Mo. Ct. App. 1996)	18
Auto Club Ins. Ass'n v. Saveco Life Ins. Co., 833 F. Supp. 637 (W.D. Mich. 1993)	20

Contents

Page

Behavioral Sciences Inst. v. Great-West Life, 84 Wash. App. 863, 930 P.2d 933 (1997) 18

Bergin v. Wausau Ins. Co., 863 F. Supp. 34 (D. Mass. 1994) 17

Brown v. Granatelli, 897 F.2d 1351 (5th Cir. 1990), *cert. denied*, 498 U.S. 848 (1990) 17

Consumer Benefit Assn. v. Lexington Ins. Co., 731 F. Supp. 1510 (M.D. Ala. 1990) 18

Cuttle v. FEMTC, 623 F. Supp. 1154 (D. Me. 1985) ... 7, 18

Drexelbrook Engineering Co. v. Travelers Ins. Co., 710 F. Supp. 590 (E.D. Pa. 1989), *aff'd*, 891 F.2d 280 (3d Cir. 1989) 17

FMC Corp. v. Holliday, 498 U.S. 52 (1990) 5, 15, 20

General Split Corp. v. Mitchell, 523 F. Supp. 427 (E.D. Wis. 1981) 18

Inter Valley Health Plan v. Blue Cross/Blue Shield of Connecticut, 16 Cal. App. 4th 60, 19 Cal. Repr. 2d 782 (1993) 18

Lincoln Mutual Casualty Co. v. Lectron, 970 F.2d 206 (6th Cir. 1992) 19, 20

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) 5, 12, 13, 14, 15, 20

Contents

Page

Michigan United Food and Commercial Worker Unions v. Baerwaldt, 767 F.2d 308 (6th Cir. 1985), *cert. denied*, 474 U.S. 1059 (1986) 20

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995) ... 15, 16

Northern Group Servs., Inc. v. Automobile Owners Ins. Co., 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988), *overruled in part* by *Lincoln Mutual, supra* 19, 20

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) 14, 15

Ramsey Co. Med. Ctr. Co. v. Breault, 525 N.W. 2d 321 (Wis. 1994) 18

St. Paul Elec. Workers Welfare Fund v. Markman, 490 F. Supp. 931 (D. Minn. 1980) 18

Thompson v. Talquin Bldg. Products Co., 928 F.2d 649 (4th Cir. 1991) 17, 21

United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga, 801 F.2d 1157 (9th Cir. 1986) 17, 18

Statutes Cited:

Section 9.31.02 of the Code of Maryland Regulations 1

Contents

	Page
15 U.S.C. § 1011, *et seq.*	3
29 U.S.C. § 1002(1)	3
29 U.S.C. § 1003(a)	2
29 U.S.C. § 1144(a)	3
29 U.S.C. § 1144(b)(2)(A)	3
29 U.S.C. § 1144(b)(2)(B)	3
22 Md. Reg. 913 (1995)	8, 9

The ERISA preemption issues presented by this case are of public importance and warrant the consideration of this Court. Consequently, Respondents[1] do not oppose the issuance of this Court's Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit. To the contrary, Respondents respectfully request that this Court issue its Writ in order to affirm the judgment of the Fourth Circuit, and thereby clarify and stabilize a critical area of ERISA preemption analysis.[2]

STATEMENT OF THE CASE

Respondents initiated this action to prevent the Maryland Insurance Administration ("MIA") from impeding the formation and operation of small self-funded ERISA plans by virtually eliminating the ability of those plans to insure themselves against catastrophic losses. Section 9.31.02 of the Code of Maryland Regulations (the "Maryland Regulation") deems stop-loss insurance that attaches below a set point to be "group health insurance." This forces self-funded ERISA plans that require stop-loss protection below those levels to: (a) risk insolvency by forgoing stop-loss protection; (b) terminate health benefits altogether; or (c) provide the benefits mandated by Maryland law. The Regulation reflects the MIA's belief that stop-loss policies that attach at very low levels are simply a sham device by which employers use the guise of self-funding to avoid the

1. The Respondents are American Medical Security, Incorporated ("AMS"), Client First Brokerage Services, Incorporated ("Client First"), Maran, Incorporated ("Maran"), Trio Metal Products, Incorporated ("Trio Metal"), and United Wisconsin Life Insurance Company ("UWLIC").

2. The Petition misrepresents the holding of the Court of Appeals for the Fourth Circuit and the factual and legal context in which the Fourth Circuit reached the conclusions articulated in its Opinion. Respondents, therefore, are constrained to file this Brief in order to correct the statement of the case and to articulate the reasons why this Court should issue its Writ.

cost of offering each of the nearly 50 health benefits mandated by Maryland law.

Both the United States District Court for the District of Maryland and the Court of Appeals for the Fourth Circuit properly concluded that the Maryland Regulation is preempted by ERISA because its articulated purpose and undisputed effect is to force self-funded ERISA plans to offer state-mandated benefits. As the Fourth Circuit concluded:

> The state's fear that plans will circumvent state regulation and offer citizens too few health benefits is understandable. But to state that fear reveals that Maryland is really concerned, not with the business of insurance and its coverage of risks, but with the benefits that ERISA plans can choose to provide their participants and beneficiaries. No matter how understandable this concern may be, only Congress may address it, not the State of Maryland through its insurance regulations.

Pet. App. 12a.

Congress enacted ERISA in 1974 to foster the growth and development of a private system of employee benefit plans and to assure the uniform and national regulation of such plans[3].

---

3. ERISA applies to any employee benefit welfare plan ("ERISA plan") established or maintained: (1) by any employer engaged in commerce or in any industry affecting commerce; or (2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or (3) by both. 29 U.S.C. § 1003(a).

(Cont'd)

ERISA placed the regulation of employee benefits under federal control, establishing a comprehensive regulatory scheme that was intended to preempt most state laws. By its terms, ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." 29 U.S.C. § 1144(a). While exceedingly broad, ERISA preemption is not absolute. In order to maintain parity with the McCarran-Ferguson Act[4], which reserved to the states the right to regulate the business of insurance, ERISA does not "exempt or relieve any person from any law of any State which regulates insurance . . . ." 29 U.S.C. § 1144(b)(2)(A). The exemption from preemption created by the "savings clause" is itself limited by the "deemer clause," which states that an ERISA plan cannot "be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance. . . ." 29 U.S.C. § 1144(b)(2)(B)[5].

(Cont'd)

An ERISA plan is:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or any employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits . . .

29 U.S.C. § 1002(1).

4. 59 Stat. 33, as amended, 15 U.S.C. § 1011, *et seq.*

5. Determining whether a state insurance law is preempted by ERISA is a three-step process. First, does the law relate to ERISA plans? If so, under the so-called "preemption clause," the law is preempted unless

(Cont'd)

Employers who have chosen to provide health care benefits to their employees generally arrange for the payment of those benefits in one of two ways. First, the employer may purchase a group health insurance policy from an insurance company which pays all health care expenses covered by the group health insurance policy. Second, the employer may create a self-funded medical expense reimbursement ERISA plan through which the employer itself pays for those health care costs for which the employer has chosen to pay.

When an ERISA plan sponsor purchases group health insurance, the plan's role in providing benefits is restricted to the payment of the group health insurance premium. It is the insurance company which issues the group health policy that directly assumes and bears all of the responsibility, and all of the liability, for paying the covered health care expenses of the plan's participants, who are the beneficiaries of the group health policy. The plan itself (usually referred to as an "insured" or "fully insured" plan) pays no claims and has no liability to the plan participants to pay health care benefits. If a dispute regarding a claim for benefits arises, plan participants have no right of action against the plan; the participant's claim is against the insurance company which, by issuing the group health policy, agreed to pay covered health care expenses on behalf of the participant.

In contrast, a self-funded ERISA plan has sole and complete responsibility, and liability, for the payment of participant's covered health care expenses. If a dispute regarding the payment

---

(Cont'd)
it saved. Second, does the state law regulate the business of insurance? If so, the law is exempt from preemption under the savings clause, unless the law runs afoul of the deemer clause. Third, does the law apply to the conduct of the ERISA plan? If so, the law is preempted by the deemer clause and cannot be enforced against ERISA plans.

of a claim for covered expenses arises, the participant's claim is against the ERISA plan itself. No insurance company is liable to participants for the payment of the benefits covered by a self-funded ERISA plan.

The payment method chosen by an ERISA plan determines whether the plan may develop its own benefit package or whether the plan must adopt a state-mandated scheme of substantive benefits. The states may not directly or indirectly regulate self-funded ERISA plans and, thus, cannot dictate the benefits offered by such plans. However, by operation of the savings clause, the states may regulate the substantive terms of insurance policies and, thus, indirectly regulate the benefits offered by fully insured plans. As this Court first concluded in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) and reaffirmed in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), "if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it." *Id.* at 64.

A fully insured plan pays premium for a group health insurance policy; benefits are paid to beneficiaries (or to health care providers on behalf of beneficiaries) by the insurance company that issued the group policy. The amount paid by the insurance company for the benefit of plan beneficiaries under the group insurance contract does not alter the premium that the insurance company agreed to charge for the group health policy. Thus, for a fully insured plan, the cost of providing benefits does not change during the term of the policy year. The opposite is true of self-funded ERISA plans.

The amount which a self-funded plan expects to contribute to the payment of benefits is based on actuarial estimates of the amount that the plan will be required to pay to health care providers on behalf of plan beneficiaries. The actual amount

that a plan is required to pay could exceed the actuarial estimates and, in some cases, the gap between actual losses and expected losses could render the self-funded plan or its sponsor insolvent. To avoid that possibility, most self-funded ERISA plans take the prudent step of purchasing stop-loss insurance.

Stop-loss insurance is a form of indemnity insurance, in the nature of reinsurance, purchased by self-funded ERISA plans (as well as other self-insuring entities) to protect against unexpected losses. The purchase of stop-loss coverage does not relieve the self-funded plan of its direct obligation to pay benefits to plan participants. Plan participants are neither parties to, nor beneficiaries of the stop-loss insurance contract and have no right of action against the stop-loss carrier.[6] A stop-loss policy does not, as Petitioner repeatedly misstates, pay health claims. Rather, a stop-loss reinsurer reimburses the self-funded plan for claims the plan is obligated to pay in excess of a stated amount known as the "attachment point."[7] As one district court judge

---

6. It is this distinction between group health insurance and stop-loss "reinsurance" which is at the heart of this case.

7. A specific (or individual) stop-loss attachment point represents the point at which the stop-loss carrier must reimburse the plan for eligible claims made by individual participants during the plan year. To illustrate, if the specific attachment point is $2,500, the plan always remains liable for the payment of *all* eligible claims submitted by each participant. However, once a given participant's eligible claims exceed $2,500 in a plan year, the plan is entitled to reimbursement from the stop-loss carrier for the amount by which that participant's claims exceed $2,500. Of course, if the plan does not pay the claim or if the plan becomes insolvent and cannot pay the claims, there is no reimbursement by the stop-loss insurer whether the attachment point has been reached or not.

Aggregate stop-loss insurance is purchased by employers to limit the amount that the plan must pay out on behalf of the entire beneficiary

(Cont'd)

accurately described it, "[s]top-loss insurance is not group health insurance providing insurance to individuals through a sponsor group. Rather, it is insurance obtained to protect self-insurers from risks beyond those upon which the premiums are based." *Cuttle v. FEMTC*, 623 F. Supp. 1154, 1157 (D. Me. 1985).

The exemption from state insurance regulation afforded self-funded ERISA plans has long been perceived as an impediment to health insurance reform by some state regulators. The Brief filed by the National Association of Insurance Commissioners ("NAIC") as *amicus curiae* in the Fourth Circuit describes activities taken by state insurance regulators to control the insurance market in order to curb perceived abuses and to increase access to health care insurance that conforms to mandates authored by the regulators. However, as the NAIC acknowledges, the efforts of individual states to dictate the kind of health insurance available to its citizens is limited, because federal laws, *particularly* ERISA, restrict the scope of state regulatory power.

The perception of ERISA as a road-block to health care cost "reform" has lead the NAIC and others to seek substantive amendments to ERISA. A specific goal of the "reformers" is the Amendment of ERISA to permit state regulation of self-funded ERISA plans that cover less than fifty participants. The NAIC has repeatedly, but unsuccessfully, urged Congress to

---

(Cont'd)
group in a given plan year. When the total amount of claims paid to participants exceeds a given point (known as the aggregate attachment point), the stop-loss carrier is obligated to reimburse the employer for the amount paid for claims in excess of that point, even if there is a specific attachment point that has not been reached with respect to any particular participant. The aggregate attachment point is generally expressed as a percentage of total expected claims.

eliminate self-funding for small and medium employers and to limit the circumstances in which self-funded plans can purchase stop-loss coverage. Having failed in those efforts, the NAIC has altered its "reform" strategies, drafting model legislation designed to circumvent ERISA and permit state regulators to gain regulatory power over the benefits structures and administration of self-funded ERISA plans by characterizing stop-loss insurance purchased by those plans as "health insurance" unless certain criteria are met.

The Maryland Regulation is based on the NAIC's Model Act.[8] The Regulation deems all ERISA plans to be "employer-sponsored group health insurance coverage" and characterizes stop-loss reinsurance as "stop-loss health insurance coverage." Pet. App. 57a. Any policy or contract issued to an employer that insures losses resulting from employee medical claims is considered to be "a policy or contract of health insurance." Pet. App. 57a-58a. Such a policy "may be considered to be a policy or contract of stop-loss health insurance coverage only if," among other things, the specific attachment points was at least $20,000 and the aggregate attachment point was at least 125% of the plan's expected claims. Pet. App. 58a.

The express purpose of the Regulation is "to define when 'stop-loss' coverage will be considered to be health insurance. . . ." 22 Md. Reg. 913 (1995). The impetus to create

8. The first form of the Maryland Regulation was not proposed until two months after this law suit was filed by Respondents. The initial basis of the Complaint was the MIA's refusal to approve UWLIC's stop-loss insurance policy because the policy did not provide for a minimum specific attachment point of $25,000. The MIA's position was premised on an unwritten, unpublished, informal, internal "policy" of the MIA adopted by unknown persons at an undisclosed point in time for reasons that had never been articulated. This protoplasmic criterion is the long standing regulation of attachment points referenced at page 4 of the Petition.

such a definition was the MIA's "concern[ ] with the protection of the residents of this State against acts by persons and insurers which deprive them of mandated health benefits" and with "the evasion of the insurance regulatory laws of the State." *Id.*

The Regulation was adopted, without a hearing, on August 24, 1995, effective September 24, 1995, and was to apply to all policies issued or renewed after January 1, 1996. The adoption of the Regulation sparked an immediate outcry, particularly by small and medium businesses, which were concerned about the effect of the high minimum attachment points on their ability to self-fund benefits. In light of public reaction, Petitioner held a public hearing in November, 1995 to consider amendments to the Regulation, including the reduction of the minimum attachment points. On December 8, 1995, Petitioner issued an Order explaining the purpose of the Regulation and, among other things, reducing the specific attachment point to $10,000 and the aggregate attachment point to 115% of expected losses. Pet. App. 38a, *et seq.*

The Commissioner's Order confirmed that the purpose of the Maryland Regulation is to control and limit the amount of risk that a self-funded plan can cede to its stop-loss insurer in order to prevent small employer plans from avoiding self-mandated benefits by self-funding. Pet. App. 41a. Indeed, Petitioner has readily acknowledged that the expected losses for small plans might fall well below the attachment points mandated by the Regulation, thereby forcing the small self-funded ERISA plan to: (a) risk insolvency by accepting a level of risk greater than that desired by the plan; (b) become fully insured; or (c) abandon its health plan.

The District Court and the Fourth Circuit correctly concluded that the Maryland Regulation is preempted by ERISA because it directly affects the administration, operation and

viability of self-funded plans. The Regulation dictates as a matter of state policy the amount of loss that a self-funded plan (regardless of size) must absorb before "reinsurance" kicks in, without regard to the judgment of the plan administrators or the size of the plan. For many small employers, the minimum attachment points set by the MIA exceed the level at which a prudent plan would insure itself against excess losses. Thus, the Regulation hinders the formation of small self-funded plans and forces existing plans to either risk insolvency, stop providing health benefits, or abandon self-funding and become fully insured.

Resolving whether the coverage purchaed by an ERISA plan is primary group health insurance or stop-loss reinsurance also resolves whether the plan purchasing the policy is fully insured or self-funded. The distinction is critical, because fully insured plans are indirectly regulated through the plan's insurer and its products, while self-funded plans are not. By relabeling stop-loss insurance as group health insurance, the Regulation purports to define as a matter of state policy when ERISA preempts the application of state laws. Having closed the door on state regulation of ERISA plans, Congress did not then hand the states the key with which to unlock it. The Regulation is but a clever means to do indirectly what the State of Maryland cannot do directly; that is, fulfill its individual vision of health care reform by controlling the benefit structures of self-funded ERISA plans. That, of course, is precisely what the ERISA preemption statute was intended to prevent.

REASONS FOR GRANTING THE WRIT

Respondents agree with Petitioners that this case presents important questions of federal law that have not been, but should be, resolved by this Court. In addition to Maryland, at least 16 other states regulate attachment points in some manner. The

minimum attachment points set by those states vary from the Maryland Regulation and from one another. *See* Petition at 9, n.3. Absent this Court's review and affirmation of the Fourth Circuit's judgment in this case, the patchwork of state regulation that ERISA was intended to eliminate will become a renewed reality for self-funded ERISA plans, particularly those, like Client First, that cover residents of more than one state.

Respondents also acknowledge the body of commentary that perceives disagreement among the Circuits as to whether the purchase of stop-loss insurance by a self-funded ERISA plan subjects the benefit structure of the plan to indirect state regulation. The majority of state and federal courts that have considered this question, including the Courts of Appeal for the Fourth, Fifth and Ninth Circuits, have concluded that stop-loss coverage does not convert an otherwise self-funded ERISA plan into a fully insured one. The Sixth Circuit, however, has reached the opposite conclusion.

While Respondents join in the request for review by this Court, the reasons asserted by Petitioners in support of the Petition are premised on an inaccurate characterization of the Fourth Circuit's opinion and, thus, skew Petitioner's analysis of the importance of this case, the nature of the disagreement among the Circuits and the proper analysis of the issues presented herein in light of prior decisions of this Court. Respondents, therefore, are constrained to address herein the reasons why this Court should issue its Writ in this case.

I.

THIS CASE PRESENTS AN IMPORTANT QUESTION OF FEDERAL LAW WHICH HAS NOT BEEN, BUT SHOULD BE, ADDRESSED BY THIS COURT.

The Fourth Circuit correctly concluded that the Maryland Regulation is a thinly disguised attempt to regulate the benefit structures of ERISA plans is thus preempted. In reaching that conclusion, the Fourth Circuit did not, as Petitioners suggest, prevent states from regulating stop-loss insurance policies. The Opinion acknowledges that "[s]uch regulation is clearly reserved to the states." Pet. App. 15a. The Fourth Circuit held, however, that not every act of a state insurance regulator is properly characterized as the regulation of insurance, and where, as here, the purpose of the state's action is to control the nature of the benefits offered by ERISA plans, the state law is not saved from preemption.

The Fourth Circuit's holding and the reasoning employed by the Court in reaching that holding does not, as Petitioner suggests, conflict with the prior rulings of this Court. The Fourth Circuit has resolved questions of ERISA preemption not directly addressed by this Court in a manner entirely consistent with precedent. The review and affirmation of the Fourth Circuit's opinion will clarify and stabilize a critical area of ERISA preemption analysis.

As this Court has remarked, the preemption framework created by ERISA is not a model of clarity and has spawned much litigation as to the boundaries of state jurisdiction. The first case in which this Court addressed this issue with respect to ERISA plans was *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), which challenged the application of Massachusetts' mandatory benefit laws to group health policies

purchased by ERISA plans. The effect of the Massachusetts law was to require ERISA plans that purchased group health policies to provide benefits that the plans did not want to provide. Thus, the Massachusetts law indirectly regulated the benefit choices of ERISA plans that funded benefits by purchasing group health insurance.

Metropolitan Life held that this indirect regulation of ERISA plan benefits was the inevitable consequence of the right to regulate the business of insurance which is reserved to the states under the savings clause. The Court recognized that its decision "results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." *Id.* at 747. "By so doing, we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter." *Id.*

Neither *Metropolitan Life* nor the decisions that follow it identify the characteristics of group health insurance that underlie this Court's conclusion that the purchase of that particular insurance product subjects an ERISA plan to indirect regulation of the benefits it provides to beneficiaries. Nor has this Court decided whether the purchase of other insurance products, such as stop-loss insurance, opens the door to the state's indirect regulation of the benefits provided by an ERISA plan. Consequently, debate among the lower courts persists as to the factors that distinguish an insured plan that is subject to indirect regulation from uninsured plan that is not subject to such regulation.[9]

---

9. Petitioner contends that the judgment of the Fourth Circuit in this case runs afoul of *Metropolitan Life* and its progeny because the Maryland Regulation focuses on the insurance companies that issue stop-loss insurance and not on the ERISA plans themselves. Pet. 12. According

(Cont'd)

The decision reached in *Metropolitan Life* was based on the Court's conclusion that the Massachusetts law was a law that regulated the business of insurance. This Court has not addressed whether a regulation (like the Maryland Regulation) that is created solely for the purpose of influencing the benefit structure of ERISA plans is properly characterized as the business of insurance and, if so, whether such a regulation can survive preemption where (as here) its inevitable and intended consequence is to destroy the self-funded nature of the plan.

In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), the Court clarified that a state law is not the regulation of the

---

(Cont'd)
to Petitioner, an ERISA plan that purchases stop-loss insurance is an insured plan and, thus, has subjected itself to indirect regulation of its benefit structure. *Id.* at 14. Petitioner argues that:

> ERISA does not pre-empt a State law that regulates insurance contracts merely because, as the court of appeals found to be the situation here, the State law has an indirect effect on employee benefit plans when it uses "insurance policies as a vehicle to impose the requirement of .... health insurance law" on those plans.

Pet. 13, quoting Pet. App. 12a. Petitioner's argument is ill-founded. *Metropolitan Life* provides no support for the proposition that the purchase of any type of insurance product by an ERISA plan subjects that plan to the "use" of the purchased policy as a means of regulating the plan's benefit structure. Petitioner's argument illustrates, however, that the intent of regulations based on the NAIC Model Act is to use the regulation of insurance products as a tool for controlling the benefit structures of ERISA plans. Petitioner would, one must assume, accept the proposition that the State could prohibit all insurance carriers from selling any form of insurance (including fire insurance, workers' compensation insurance, business risk insurance) to employers or employer sponsored plans that fail to provide mandated benefits.

business of insurance merely because the law has some effect upon the insurance industry; the law must be specifically directed toward the industry and may not regulate the conduct of non-insurers. *Id.* at 50. *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), reiterated the breadth of ERISA preemption, emphasizing that, while state regulations must be reviewed in accordance with the traditional three-part preemption analysis, the overarching inquiry is whether the state law violates the goals Congress intended to achieve in enacting ERISA. *Id.* at 57-58. Most recently, in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), this Court held that state laws of general application that are not specifically directed at or connected to ERISA plans and which have only an indirect economic impact on ERISA plans do not "relate to" the plans and do not trigger preemption. However, the *Travelers* Court recognized that such a law would be preempted if the indirect costs to the ERISA plan were so high that those costs forced the plan to adopt a certain scheme of substantive benefits or effectively restricted the plan's choice of funding, or forced the plan out of existence. *Id.* at 668.

While each of these cases lends guidance to the issue presented by this case, none addresses those issues squarely. This case, however, does present the questions left open by *Metropolitan Life* and its progeny. First, the opinion of the Fourth Circuit is premised, in part, upon the Court's conclusion that the purchase of stop-loss insurance by ERISA plans does not convert otherwise self-funded plans into fully insured plans subject to indirect state regulation. Second, the Fourth Circuit concluded that the Regulation, however artfully drafted, does not regulate the business of insurance because it is directed at the relationship between the plan and its participants and not at the relationship between the plan and its stop-loss insurer. Finally, the Regulation was found to be preempted because its inevitable effect would be to eliminate small self-funded ERISA plans.

In *Travelers*, Mr. Justice Souter seemed to invite the opportunity to review a case like the one at bar when he included the following language as *obiter dicta* in the *Travelers* opinion:

> We acknowledge that a state law might produce such acute, albeit indirect economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be preempted under § 514.

Travelers, 514 U.S. at 668.

This case presents precisely those circumstances described by Mr. Justice Souter and is the ideal vehicle by which this Court may clarify the boundaries of state jurisdiction when state action threatens the autonomy and, indeed, the very existence of certain self-funded ERISA plans.

The Maryland Regulation represents a growing effort by the NAIC and the regulators of at least sixteen other states to overrun the barriers of ERISA preemption and, under the guise of state insurance regulation, heap each state's particular (but frequently divergent) concept of health insurance "reform" upon the large number of self-funded ERISA plans that purchase stop-loss insurance.[10] Because the Fourth Circuit does not encompass all states which regulate stop-loss attachment points, this Court should review and affirm the judgement issued by the Fourth Circuit in this case, thereby ending ongoing state efforts to encroach on ERISA plan practices.

---

10. As the Petition states, as of July, 1995, 114 million Americans (44% of the U.S. population) received health insurance benefits through ERISA plans. Forty percent of ERISA plans (covering 44 million people) were self-funded. Over 70% of self-funded ERISA plans purchased some level of stop-loss insurance. Pet. 8-9.

II.

THERE IS A BODY OF COMMENTARY THAT PERCEIVES AN IRRECONCILABLE SPLIT AMONG THE CIRCUIT COURTS.

Consideration by this Court is necessary because, as Petitioner correctly asserts, there are those who perceive a split among the Circuit Courts regarding how, if at all, the purchase of stop-loss coverage effects the self-funded nature of ERISA plans. The Courts of Appeal for the Fourth, Fifth, Sixth, and Ninth Circuit have addressed this issue. The majority view, subscribed to by the Fourth, Fifth and Ninth Circuits, is that stop-loss insurance does not convert an otherwise self-funded plan into a health insurance policy subject to indirect state regulation[11]. Even in the Circuits that have not addressed the issue, the prevailing view of the United States District Courts, including District Courts located in Alabama, Maine, Massachusetts, Minnesota, Pennsylvania, and Wisconsin,[12] is

---

11. *See, e.g., Thompson v. Talquin Bldg. Products Co.*, 928 F.2d 649 (4th Cir. 1991) (stop-loss insurance does not convert a self-funded ERISA plan into an insured plan); *Brown v. Granatelli*, 897 F.2d 1351 (5th Cir. 1990), *cert. denied*, 498 U.S. 848 (1990) (state law does not regulate employer's self-insured plan with stop-loss coverage; distinguishes between stop-loss insurance and primary coverage on basis that stop-loss only covers plan itself and plan is still liable to employees; does not reach ERISA preemption issue); *United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986) (self-insured ERISA Plan which carries stop-loss insurance is not to be considered a health insurance policy).

12. *Bergin v. Wausau Ins. Co.*, 863 F. Supp. 34, 37, n.4 (D.Mass. 1994) (concluding that ERISA's deemer clause preempted application of state law against plan with stop-loss insurance); *Drexelbrook Engineering Co. v. Travelers Ins. Co.*, 710 F. Supp. 590, 597 (E.D. Pa. 1989), *aff'd*, 891 F.2d 280 (3d Cir. 1989) (recognizing that ERISA plan that purchases stop-loss insurance is the insured, not the individual employees; therefore

(Cont'd)

that the purchase of stop-loss insurance does not convert a self-funded plan into a fully insured plan and that stop-loss coverage is not group health insurance.[13] Several state courts have also adopted the majority view.[14]

The majority view, reiterated by the Fourth Circuit in this case, is premised on "the real distinction between self-funded plans, with or without stop-loss insurance, and fully insured plans." App. 12a.

(Cont'd)
plan with stop-loss coverage remains uninsured); *Cuttle v. FEMTC*, 623 F. Supp. 1154, 1157 (D. Me. 1985) (holding that stop-loss insurance is not insurance for plan participants, so self-funded plans purchasing stop-loss insurance are not subject to Maine conversion laws); *General Split Corp. v. Mitchell*, 523 F. Supp. 427, 430-431 (E.D. Wis. 1981) (state-mandated benefit statute preempted as applied to self-funded ERISA plan that purchased stop-loss insurance); *St. Paul Elec. Workers Welfare Fund v. Markman*, 490 F. Supp. 931 (D. Minn. 1980) (mandated benefit law preempted as applied to self-funded ERISA plan with stop-loss insurance).

13. *Consumer Benefit Assn. v. Lexington Ins. Co.*, 731 F. Supp. 1510, 1511, 1513 (M.D. Ala. 1990) (noting that any breaches between stop-loss insurer and plan participants in no way affect the plan participant's entitlement to benefits).

14. *Inter Valley Health Plan v. Blue Cross/Blue Shield of Connecticut*, 16 Cal. App. 4th 60, 64, 19 Cal. Repr. 2d 782 (1993) (state insurance regulation of self-funded plans with stop-loss insurance is preempted; despite contrary authority from the Sixth Circuit, the California court found *Pacyga* to be the better reasoned case); *Associated Industs. of Missouri v. Angoff*, 937 S.W. 2d 277, 282-284 (Mo. Ct. App. 1996) (finding that Missouri Insurance Commissioner's authority to regulate health insurance does not extend to stop-loss insurance); *Behavioral Sciences Inst. v. Great-West Life*, 84 Wash. App. 863, 930 P.2d 933 (1997) (concluding that since stop-loss insurer has no obligation to plan participants, employer-sponsor's claims against stop-loss insurer are not preempted by ERISA); *Ramsey Co. Med. Ctr. Co. v. Breault*, 525 N.W. 2d 321 (Wis. 1994) (purchase of stop-loss insurance does not destroy employee benefit plan's status as self-funded).

> Under a self-funded plan, the employer who promises the benefit incurs the liability defined by the plan's terms. That liability remains the employer's even if it has purchased stop-loss insurance and even if the stop-loss insurer becomes insolvent. Conversely, if the employer becomes insolvent, the solvency of the stop-loss insurer may not benefit plan participants and beneficiaries. This is because their claims against the insurer, would be derivative of the plan's claim against the insurer, which arises only after the plan actually makes benefit payments beyond the agreed attachment point. In contrast, when a plan buys health insurance for participants and beneficiaries, the plan participants and beneficiaries have a legal claim directly against the insurance company, thereby securing the benefits even in the event of the plan's insolvency. Participant and beneficiaries in self-funded plans may not have the security of the insurance company's assets because stop-loss insurance insures the plan and not the participants.

Pet. App. 13a.

The Court of Appeals for the Sixth Circuit is the only Circuit Court which has ever concluded that the purchase of a form of stop-loss coverage can convert a self-funded ERISA plan into a fully insured plan subject to indirect regulation by the State.[15]

---

15. *See, e.g., Lincoln Mutual Casualty Co. v. Lectron*, 970 F.2d 206 (6th Cir. 1992); *Northern Group Servs., Inc. v. Automobile Owners Ins.*

(Cont'd)

The Sixth Circuit reasons that under *Metropolitan Life*, which applied specifically to fully insured plans, state insurance laws are not preempted under ERISA, and that "the 'stop-loss' nature of the plans does not alter [that] conclusion." *Michigan United Food and Commercial Worker Unions v. Baerwaldt*, 767 F.2d 308, 312 (6th Cir. 1985), *cert. denied*, 474 U.S. 1059 (1986)[16].

The minority view of the Sixth Circuit is wrong because it misconstrues the nature of stop-loss insurance. The Sixth Circuit fails to recognize any distinction between standard health plans and stop-loss insurance in reasoning that "[a]s long as the [ERISA] plans purchase insurance from 'an insurer offering health insurance policies in' Michigan, the policies must include the substance abuse coverage specified [under Michigan law]." *Baerwaldt*, 767 F.2d at 313. Also, the Sixth Circuit's holdings completely fail to consider the effect of the state laws on Congress' goal of achieving uniformity for ERISA plans.

The Fourth Circuit noted the Sixth Circuit's *Northern Group* holding, but found the reasoning to be unpersuasive:

(Cont'd)
Co., 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988), *overruled in part* by *Lincoln Mutual, supra*; *Michigan United Food and Commercial Worker Unions v. Baerwaldt*, 767 F.2d 308 (6th Cir. 1985), *cert. denied*, 474 U.S. 1059 (1986).

16. At least one federal court within the Sixth Circuit has concluded that the reasoning of *Baerwaldt* is unsound and that, in light of this Court's holding in *FMC Corp. v. Holliday*, *Baerwaldt* and its progeny are no longer good law. *See Auto Club Ins. Ass'n v. Saveco Life Ins. Co.*, 833 F. Supp. 637, 642 (W.D. Mich. 1993) (holding that stop-loss insurance is not a policy for health benefits and stating that: "[t]he rational for not treating stop-loss insurance as health insurance is better explained by rulings in other circuits," such as the Fourth Circuit, rather than by Sixth Circuit precedent).

> Even with the stop-loss coverage, Talquin's Plan is directly liable to Talquin's employees for any amount of benefits owed to them under the Plan's provisions. The purpose of the stop-loss insurance is to protect Talquin from catastrophic losses, it is not accident and health insurance for employees. Instead of covering employees directly, the stop-loss insurance covers the Plan itself. Thus, for the purposes of ERISA, the Plan remains self-funded even with the stop-loss insurance.

Talquin, 928 F.2d 649, 653.

The existence of the NAIC Model Act, the Maryland Regulation and stop-loss regulations promulgated by other states establishes that, as long as it can be reasonably argued that the Sixth Circuit stands against the majority, states will continue to use the existence of stop-loss coverage as an excuse to manipulate and control ERISA plan benefits. The time is ripe to resolve the conflict created by the Sixth Circuit's renegade rulings and to make clear to state regulators that the purchase of stop-loss insurance by a self-funded ERISA plan does not subject those plans to any form of state regulation.

CONCLUSION

This Court should issue its Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit, not for the reasons articulated by Petitioner, but for those asserted herein by Respondents. Following review, the judgment of the Fourth Circuit should be affirmed.

Respectfully submitted,

EDWARD J. BIRRANE, JR.
Counsel of Record
CYNTHIA M. DIETZ
EDWARD J. BIRRANE, JR. Chartered
28 West Allegheny Avenue
Suite 606
Towson, Maryland 21204
(410) 823-0464

ANDREW JAY GRAHAM
KATHLEEN A. BIRRANE
Kramon & Graham, P.A.
One South Street
Suite 2600
Baltimore, Maryland 21202
(410) 752-6030

Attorneys for Respondents

No. 97-218

Supreme Court, U.S.
FILED
OCT 6 1997
CLERK

In The

Supreme Court of the United States

October Term, 1996

STEVEN B. LARSEN, IN HIS CAPACITY AS INSURANCE COMMISSIONER OF THE STATE OF MARYLAND,

Petitioner,

v.

AMERICAN MEDICAL SECURITY, INC., ET AL.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

BRIEF OF THE STATES OF MINNESOTA, ARIZONA, CALIFORNIA, COLORADO, DELAWARE, DISTRICT OF COLUMBIA, GEORGIA, HAWAII, IDAHO, KANSAS, MAINE, MASSACHUSETTS, MICHIGAN, MISSOURI, MONTANA, NEVADA, NEW HAMPSHIRE, NEW YORK, NORTH CAROLINA, NORTH DAKOTA, OREGON, TEXAS, VERMONT AS AMICI CURIAE IN SUPPORT OF PETITIONER

HUBERT H. HUMPHREY III
Attorney General
State of Minnesota

AUDREY KAISER MANKA
Assistant Attorney General
Counsel of Record

Capitol Office Building, Suite 500
525 Park Street
St. Paul, MN 55103
(612) 297-5933

Attorneys for Amicus Curiae State of Minnesota

(Additional Counsel For Amici States Listed On Inside Cover)

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

49 pp

GRANT WOODS
Attorney General
State of Arizona

DANIEL E. LUNGREN
Attorney General
State of California

GALE A. NORTON
Attorney General
State of Colorado

M. JANE BRADY
Attorney General
State of Delaware

JO ANNE ROBINSON
Interim Corporation Counsel
District of Columbia

THURBERT E. BAKER
Attorney General
State of Georgia

MARGERY S. BRONSTER
Attorney General
State of Hawaii

ALAN G. LANCE
Attorney General
State of Idaho

CARLA J. STOVALL
Attorney General
State of Kansas

ANDREW KETTERER
Attorney General
State of Maine

SCOTT HARSHBARGER
Attorney General
State of Massachusetts

FRANK J. KELLEY
Attorney General
State of Michigan

JEREMIAH W. (JAY) NIXON
Attorney General
State of Missouri

JOSEPH P. MAZUREK
Attorney General
State of Montana

FRANKIE SUE DEL PAPA
Attorney General
State of Nevada

PHILIP T. MCLAUGHLIN
Attorney General
State of New Hampshire

DENNIS C. VACCO
Attorney General
State of New York

MICHAEL F. EASLEY
Attorney General
State of North Carolina

HEIDI HEITKAMP
Attorney General
State of North Dakota

HARDY MEYERS
Attorney General
State of Oregon

DAN MORALES
Attorney General
State of Texas

WILLIAM H. SORRELL
Attorney General
State of Vermont

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

STATEMENT OF INTEREST 1

REASONS FOR GRANTING REVIEW 6

I. THE COURT OF APPEALS ERRONEOUSLY INTERPRETED THE ERISA PREEMPTION STANDARD IN A CASE THAT PRESENTS AN UNRESOLVED MATTER OF NATIONWIDE SIGNIFICANCE 6

II. THE DECISION BELOW CONFLICTS WITH THIS COURT'S DECISIONS IN *METROPOLITAN LIFE INS. CO. V. MASSACHUSETTS*, 471 U.S. 724 (1985), AND *FMC CORP. V. HOLLIDAY*, 498 U.S. 52 (1990) 8

III. THE DECISIONS OF THE CIRCUIT COURTS OF APPEALS ARE DIVIDED ON THE ISSUE PRESENTED 10

CONCLUSION 14

TABLE OF AUTHORITIES

Page

FEDERAL STATUTES

15 U.S.C. § 1012 (1994) 2

29 U.S.C. §§ 1001-1461 (1974) ..... *passim*

29 U.S.C. § 1144(a) (1994) 6

29 U.S.C. § 1144 (b)(2)(A) (1994) 2, 6

29 U.S.C. § 1144(b)(2)(B) (1994) 6

MINNESOTA STATUTES

Minn. Stat. § 60A.235 (1995) 5

STATUTES OF OTHER JURISDICTIONS

1997 Alaska Sess. Laws, Ch. 81 5

Colo. Rev. Stat. § 10-16-119 (1995) 5

Me. Rev. Stat. Ann., Tit. 24A § 707(1)(C-1) (1994) and June 5, 1992 Guideline 5

Mo. Code Regs. Title 20, § 400-2.150 (1995) 5

Or. Rev. Stat. § 742.065 (1995) 5

Tenn. Code Ann. § 56-2-201(1) (1994) 5

Wash. Rev. Code § 48.21.015 (1995) 5

FEDERAL DECISIONS

Brown v. Granatelli, 897 F.2d 1351 (5th Cir. 1990) 12, 13

DeBuono v. NYSA-ILA Medical and Clinical Services Fund, 117 S. Ct. 1747 (1997) 3

TABLE OF AUTHORITIES – Continued

Page

FMC Corp. v. Holliday, 498 U.S. 52 (1990) 8, 9

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) ..... *passim*

Michigan United Food & Commercial v. Baerwaldt, 767 F.2d 308 (6th Cir. 1985), *cert. denied*, 474 U.S. 1059 (1986) 11, 13

Moore v. Provident Life & Accident Ins. Co., 786 F.2d 922 (9th Cir. 1986) 12

New York State Conference of Blue Cross and Blue Shield Plans v. The Travelers Ins. Co., 115 S. Ct. 1671 (1995) 3, 11, 12

Safeco Life Ins. Co. v. Musser, 65 F.3d 647 (7th Cir. 1995) 11

Travelers Ins. Co. v. Cuomo, 14 F.3d 708 (2d Cir. 1993), *rev'd on other grounds*, 115 S. Ct. 1671 (1995) 11

United Foods and Commercial Workers v. Pacyga, 801 F.2d 1157 (9th Cir. 1986) 12

STATE DECISIONS

American Trust Adm'rs, Inc. v. Sebelius, No. 96-CV-908 (Kan. Dist. Ct. Shawnee Cty. April 25, 1997) 11

RULES AND REGULATIONS OF OTHER JURISDICTIONS

27 N.J. Reg. 4320 5

Ok. Bulletin March 20, 1991 5

Pa. Bulletin Vol. 22, No. 39 (1992) 5

Tenn. Comm. and Ins. Bulletin October 18, 1995 5

TABLE OF AUTHORITIES – Continued

Page

SECONDARY AUTHORITIES

Jeffrey Lenhardt, *ERISA Preemption: The Effect of Stop-Loss Insurance on Self-Insured Health Plans*, 14 Va. Tax. Rev. 615 (1995) 11

Jolee Ann Hancock, *Diseased Federalism: State Health Care Laws Fall Prey to ERISA Preemption*, 25 Cumb. L. Rev. 383 (1995) 3

Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. Davis L. Rev. 255 (1990)..... 3

U.S. General Accounting Office, *Employer Based Health Plans: Issues, Trends, and Challenges Posed by ERISA*, GAO/HEHS-95167, July, 1995 3

BRIEF OF AMICI CURIAE IN SUPPORT OF PETITIONER

Pursuant to Supreme Court Rule 37, the signatory states respectfully submit this brief as amici curiae in support of Maryland's petition for a writ of certiorari.

STATEMENT OF INTEREST

The amici states have a strong interest in the resolution of the issue presented by this case because it has implications for two interrelated aspects of the states' police power functions: regulation of the insurance industry and maintenance of a stable and effective health care delivery system. If the decision of the Fourth Circuit is allowed to stand, and proliferate, each state's ability to perform those crucial functions for the protection of the health and welfare of the citizens will be significantly undermined.

As this Court has acknowledged, all states have long been involved in the active regulation of the insurance industry for the protection of their citizens. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 728 (1985). This regulation has ranged from assuring financial stability of companies offering insurance to mandating the substantive content of specific types of policies offered. *Id.* Specifically relevant to this case, the sale of health insurance has been subject to extensive regulation by the states. *Id.* Significantly, Congress has consistently and explicitly left regulation of the insurance industry to the states. *See*

McCarran-Ferguson Act, 15 U.S.C. § 1012 (1994)[1]; 29 U.S.C. § 1144(b)(2)(A) (1994) (ERISA insurance savings clause).

States also have played a long-standing role in the regulation of their health care systems. That role has been highlighted in recent years as states have enacted reforms intended to address the dual challenges of containing skyrocketing costs while providing adequate, quality care to all those in need.

By holding that Maryland's regulation of stop-loss insurance purchased by employer health benefit plans is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461, the Fourth Circuit's decision improperly infringes on both of these traditional police power functions of the states. Thus, the ruling below interferes with the proper balance between important state police powers and federal authority under ERISA.

The threat to the states' authority posed by the Fourth Circuit's decision is magnified by the scope of ERISA's reach. The United States General Accounting

---

[1] Section 1012 provides:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance. . . .

15 U.S.C. § 1012 (1994).

Office recently estimated that 114 million individuals, or 44 percent of the U.S. population, were enrolled in ERISA health benefit plans in 1993. *See* U.S. General Accounting Office, *Employer Based Health Plans: Issues, Trends, and Challenges Posed by ERISA*, GAO/HEHS-95167, July, 1995, at 2. The broad impact that ERISA preemption decisions have on the ability of states to implement effective improvements in their health care systems is well-documented. *See* Jolee Ann Hancock, *Diseased Federalism: State Health Care Laws Fall Prey to ERISA Preemption*, 25 Cumb. L. Rev. 383 (1995); Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. Davis L. Rev. 255 (1990). Indeed, the proper scope of ERISA preemption in relation to the financing aspects of state health care systems has been before the Court in two recent Terms. *See New York State Conference of Blue Cross and Blue Shield Plans v. The Travelers Ins. Co.*, 115 S. Ct. 1671 (1995); *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 117 S. Ct. 1747 (1997).

The issue of the states' authority to regulate stop-loss insurance sold to self-funded ERISA health benefit plans, one of the leading challenges posed by ERISA, now has come to the fore. As reported by the General Accounting Office, almost forty percent of ERISA health benefit plans, covering 44 million people, are at least partially self-funded.[2] *See* U.S. General Accounting Office, *Employer Based Health Plans: Issues, Trends, and Challenges Posed by ERISA*, GAO/HEHS-95167, July, 1995, at 2-3. The

---

[2] In this brief the terms "self-insurance" and "self-funded" are used interchangeably.

General Accounting Office found further that self-funding of ERISA plans was increasing, especially among smaller firms. *Id.* at 3.

Typically, ERISA plans provide health benefits to their employees either through the purchase of insurance or by self-insuring. As the General Accounting Office noted, however, the distinction between self-insured and fully insured plans "is growing more difficult as the health market changes. Among factors contributing to the confusion are more extensive use of stop-loss coverage and innovative arrangements between employers and managed care organizations." *Id.* at 8. The General Accounting Office also found that there is an "increasingly blurred distinction between self-funded and insured plans. . . . This results partly because employers are increasingly adopting funding arrangements that are neither fully insured nor fully self-funded." *Id.* at 3.

Stop-loss insurance typically has been viewed as business insurance to protect the insured from excessive claims based upon unexpected or catastrophic losses. Maryland recognized a trend whereby insurers issue stop-loss policies to self-funded health care plans that insure the risk at low attachment points. Such policies allow employers to shift more risk to the insurer. Insurance regulators in Maryland and other states have determined that by shifting more risk to the insurer, the stop-loss insurance functions more like direct health insurance and less as catastrophic stop-loss insurance. Consequently, the State of Maryland adopted regulations that impose the same requirements on stop-loss policies that function effectively as health care policies that are imposed on health care policies. In defining the point at

which "stop-loss" insurance would be treated as health insurance, the State of Maryland properly asserted its police powers over the insurance companies, requiring the insurance companies issuing those policies to comply with the consumer protection provisions required for health insurance. Such state action is necessary and appropriate to protect the consumers of the health insurance at issue. Further, it is an appropriate exercise of state police power as that authority has been reserved for the states under the McCarran-Ferguson Act.

The State of Maryland is not alone. Numerous states have adopted laws and issued interpretations to address this changing market and the blurring of lines between insured and self-insured plans.[3]

This Court has made it clear that ERISA plans that purchase group health insurance policies are subject to indirect regulation that results from the states' regulation of the insurance industry. *See Metropolitan Life*, 471 U.S. 724 (1985). The Court has not addressed the application of that principle to stop-loss insurance, and the federal courts of appeals that have addressed the issue are divided in their results. The Fourth Circuit's resolution of the issue not only failed to follow the decisions of this

---

[3] *See* 1997 Alaska Sess. Laws, Ch. 81; Colo. Rev. Stat. § 10-16-119 (1995); CT Bulletin PC-7-90; Ks. Bulletin 1993-12 and 1997-7, Me. Rev. Stat. Ann., Tit. 24A § 707(1)(C-1) (1994) and June 5, 1992 Guideline; Minn. Stat. § 60A.235 (1995); Mo. Code Regs. Title 20, § 400-2.150 (1995); 27 N.J. Reg. 4320; Ok. Bulletin March 20, 1991; Or. Rev. Stat. § 742.065 (1995); Pa. Bulletin Vol. 22, No. 39 (1992); Tenn. Comm. and Ins. Bulletin October 18, 1995 and Tenn. Code Ann. § 56-2-201(1) (1994); and Wash. Rev. Code § 48.21.015 (1995).

Court, but severely limited the authority of the states to carry out their traditional duties to protect the health and welfare of their citizens. Until this Court speaks to the issue, states will be faced with an increasing number of insurance products that are labeled as "stop-loss" insurance to distinguish themselves from "health" insurance and thus avoid state regulation, when in fact they act as health insurance and should be regulated as such. The amici states therefore urge the Court to issue a writ of certiorari so it can address this increasingly important issue.

REASONS FOR GRANTING REVIEW

I. THE COURT OF APPEALS ERRONEOUSLY INTERPRETED THE ERISA PREEMPTION STANDARD IN A CASE THAT PRESENTS AN UNRESOLVED MATTER OF NATIONWIDE SIGNIFICANCE.

This case focuses on an unresolved ERISA preemption issue which triggers the complex interaction of: the general ERISA preemption clause, 29 U.S.C. § 1144(a) (1994); the insurance savings clause, 29 U.S.C. § 1144(b)(2)(A) (1994); and the deemer clause, 29 U.S.C. § 1144(b)(2)(B) (1994). In reconciling these opaque provisions, the Court has distinguished ERISA plans that provide benefits to their employees through the purchase of insurance from ERISA plans that self-insure, allowing states to regulate insurance companies, and thus indirectly regulate ERISA plans that purchase insurance, but prohibiting direct state regulation of self-insured ERISA plans. *Metropolitan Life v. Massachusetts*, 471 U.S. 724, 747 (1985). The instant case asks whether an employee benefit

plan can insulate itself from the indirect regulation recognized in *Metropolitan Life* merely by insuring something less than all of its risk.

The decision below effectively negates ERISA's insurance savings clause for an increasingly significant portion of the insurance market, thus thwarting Congress' express intent that the states retain their authority to regulate the business of insurance. The Maryland regulation at issue is not directed at ERISA plans. Rather, it is designed to prevent sham transactions whereby health insurance with a high deductible is labeled as stop-loss insurance by insurance companies to avoid state insurance regulation. The decision of the Court of Appeals invites subterfuge in the insurance industry. It also assumes that the insurance savings clause and deemer clause, when read together, prohibit the states from regulating a specific type of insurance. Nothing in the language of ERISA demands that result.

The Maryland regulation at issue is not an isolated or atypical state insurance law, and the problem it addresses is not unique to Maryland. The harm the Maryland regulation targets is precisely the type of harm which the states are best suited to address. It targets sharp business practices whereby form is placed above substance. As demonstrated in a recent enforcement action in Minnesota, consumer protection regulations similar to the Maryland regulation at issue protect the employers who purchase the insurance as well as their employees. Appendix at 17a. Moreover, the type of stop-loss insurance that precipitated the Maryland regulation is only one example of attempts by entities that provide health benefits to shift some of that risk to other parties. Shifting

of risk is a hallmark of the business of insurance and the states must be free to address these new and innovative ways of shifting risk if they are to carry out their duty to protect the public health and welfare.

II. THE DECISION BELOW CONFLICTS WITH THIS COURT'S DECISIONS IN *METROPOLITAN LIFE INS. CO. V. MASSACHUSETTS*, 471 U.S. 724 (1985), AND *FMC CORP. V. HOLLIDAY*, 498 U.S. 52 (1990).

The decision below directly conflicts with the prior decisions of this Court in *Metropolitan Life v. Massachusetts*, 471 U.S. 724, 747 (1985) and *FMC Corp. v. Holliday*, 498 U.S. 52 (1990). In *Metropolitan Life*, the Court held that a mandated-benefit law was state regulation of insurance within the meaning of the insurance savings clause and thus was saved from preemption under ERISA. A critical holding in that case recognized that the insurance contract between the plan and an insurer is saved from preemption, and that contract may be regulated by the states without invoking the deemer clause. Under the *Metropolitan Life* analysis, if a plan is completely self-insured the "deemer clause" prohibits the states from regulating the benefits provided by the plan. The Court recognized that such a distinction results in different rules applying to plans depending on whether the plan is self-insured:

> We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in

> the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter.

Id., 471 U.S. at 747. Accordingly, a plan that purchases insurance from a regulated insurer is subject to indirect regulation while self-insured plans are exempt from regulation under the deemer clause.

The Court reaffirmed *Metropolitan Life* in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), holding that the "deemer clause" exempts self-funded ERISA plans from state laws that "regulate insurance" within the meaning of the savings clause. *Id.* at 61. The Court explained:

> State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state regulation. An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.

Id. at 61.

The Fourth Circuit erroneously failed to apply this Court's very clear directive. The regulation at issue is directed at stop-loss insurers, not ERISA plans. Those insurers should not be relieved from state regulation merely because they have sold their insurance to "self-

insured" employers. Similarly, the ERISA plans that purchase that insurance are indirectly subject to the state's regulation because they have chosen to purchase insurance to cover some of their risk, rather than remaining fully self-insured. The loophole created by the Fourth Circuit decision significantly erodes the states' ability to exercise their traditional regulation of insurance that Congress intended to protect with the insurance savings clause. By curtailing the states' ability to distinguish between true catastrophic or stop-loss insurance and traditional health insurance, the Court of Appeals invites the creation of a shadow insurance market that remains unregulated by either federal or state authority and is devoid of the protections that regulation would provide.

III. THE DECISIONS OF THE CIRCUIT COURTS OF APPEALS ARE DIVIDED ON THE ISSUE PRESENTED.

Review of the Court of Appeals' decision is necessary to resolve conflicting decisions issued by several courts of appeals. The Courts of Appeals for the Sixth Circuit and Seventh Circuit have opined that various state regulations are not preempted even though they act on stop-loss insurance purchased by ERISA plans. The Courts of Appeals for the Second Circuit and Ninth Circuit, however, determined that the purchase of stop-loss insurance does not convert ERISA plans to insured plans for purposes of the preemption analysis. This split in the courts has created uncertainty and confusion that can be resolved only by this Court. As noted by one commentator, "[e]ven those courts that ultimately agree on the issue

seldom employ the same analysis in arriving at their decisions; there is not only inconsistency between the circuits, there is even inconsistency within a circuit." Jeffrey Lenhardt, *ERISA Preemption: The Effect of Stop-Loss Insurance on Self-Insured Health Plans*, 14 Va. Tax. Rev. 615, 638 (1995).

In *Michigan United Food & Commercial v. Baerwaldt*, 767 F.2d 308 (6th Cir. 1985), *cert. denied*, 474 U.S. 1059 (1986), the Court of Appeals properly relied on the *Metropolitan Life* decision of this Court noting: "[T]he 'stop-loss' nature of the plans does not alter our conclusion. . . . As long as the plans purchase insurance from 'an insurer offering health insurance policies in Michigan, the policies must include the substance abuse coverage specified. . . . ' " *Id.* at 312-13.

Likewise, the Court of Appeals for the Seventh Circuit concluded an assessment imposed on sales by insurance companies may include sales of stop-loss insurance to self-funded ERISA plans. That court, following this Court's decision in *Travelers*, 115 S. Ct. 1671 (1995), held that the imposition of a fee on the insurer selling stop-loss insurance to an ERISA plan does not trigger federal preemption. *See Safeco Life Ins. Co. v. Musser*, 65 F.3d 647 (7th Cir. 1995).[4]

The Court of Appeals for the Ninth Circuit, however, ruled that the purchase of stop-loss insurance by ERISA

---

[4] At least one state court has considered and rejected the analysis of the Fourth Circuit, choosing instead to rely on the Seventh Circuit's analysis. *American Trust Adm'rs, Inc. v. Sebelius*, No. 96-CV-908 (Kan. Dist. Ct. Shawnee Cty. April 25, 1997) Appendix at 1a, 7a.

plans did not convert those plans into insured plans. *See Moore v. Provident Life & Accident Ins. Co.*, 786 F.2d 922 (9th Cir. 1986), and *United Food and Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986). The Court of Appeals for the Second Circuit found ERISA preempted an Actuarial Letter issued by the State of New York that regulated stop-loss insurance contracts. *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708 (2d Cir. 1993), *rev'd on other grounds*, 115 S. Ct. 1671 (1995).

Interestingly, the Court of Appeals for the Fifth Circuit in *Brown v. Granatelli*, 897 F.2d 1351 (5th Cir. 1990), did not reach the question of whether the stop-loss insurance at issue there was preempted by ERISA because it concluded, "with one important qualification," that stop-loss insurance was not health and accident insurance. *Id.* at 1354. The "important qualification," however, is critical to the case at issue. That court noted:

> We do not suggest that Article 3.70-2(E) can be avoided by naming an employer benefit plan as the insured on a policy which in reality insures the plan participants. If, for example, a plan paid only the first $500.00 of a beneficiaries' health claim, leaving all else to the insurer, labeling its coverage stop-loss or catastrophic coverage would not mask the reality that it is close to the simple purchase of group accident and sickness coverage. We look beyond form to the substance of the relationship between the plan, the participants, and the insurance carrier to see whether the plan is in fact purchasing insurance for itself and not for the plan participants, recognizing that as insurance is less for

> catastrophic loss, it is increasingly like accident and sickness insurance for plan participants.

Id. at 1355.

Further, in a well-reasoned dissent, Judge Brown agreed with the Court of Appeals for the Sixth Circuit in *Michigan United Food* and stated that he would hold the stop-loss policy at issue in *Granatelli* was group accident and sickness insurance under Texas law. He recognized the issue presented was essentially a state law question and suggested that a better course would be to certify the matter to the Supreme Court of Texas, observing, however, that if the Court of Appeals for the Fifth Circuit reached the ERISA issue it should follow this Court's guidance in *Metropolitan Life*. *Granatelli*, 897 F.2d at 1356-59 (Brown, J., dissenting).

Clearly the federal appellate courts are split in their approach to handling this important issue, and thus it is imperative that this Court speak on the matter.

CONCLUSION

For the reasons stated above, the amici states respectfully urge this Court to issue a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit.

Dated: September, 1997

Respectfully submitted,

HUBERT H. HUMPHREY III
Attorney General
State of Minnesota

AUDREY KAISER MANKA
Assistant Attorney General
Counsel of Record

Capitol Office Building, Suite 500
525 Park Street
St. Paul, MN 55103
(612) 297-5933

Attorneys for Amicus Curiae
State of Minnesota

[Additional Counsel Listed On Inside Cover]

TABLE OF CONTENTS

Page

American Trust Adm'rs., Inc. v. Sebelius, No. 96-CV-908 (Kan. Dist. Ct. Shawnee Cty. April 25, 1997) 1a

September 20, 1995 Consent Order of the Minnesota Commissioner of Insurance *In the Matter of the Certificate of Authority of United Wisconsin Insurance Company and American Medical Security, Inc.* 17a

IN THE DISTRICT COURT OF
SHAWNEE COUNTY, KANSAS
DIVISION SIX

AMERICAN TRUST ADMINISTRATOR'S, INC., Petitioner,	)	Case No. 96-CV-908
v.	)	
KATHLEEN SEBELIUS, as Commissioner of Insurance for the State of Kansas, Respondent.	)	

MEMORANDUM DECISION AND ORDER

This case comes before the Court on American Trust Administrator's (ATA) Petition for Judicial Review. After careful consideration of the party's briefs, and for the reasons set forth below the Court hereby grants ATA's Petition for Judicial Review and overturns the decision of the Commissioner to disapprove the stop loss policy submitted by ATA.

FACTUAL BACKGROUND

The Commissioner of Insurance (Commissioner) issued Bulletin 1993-12 on May 25, 1993 and amended it on October 26, 1993. Bulletin 1993-12 reads, in relevant part:

1. The stop loss or excess loss policy shall be issued to and insure the plan or plan sponsor, not the individual participants.

2. Payment by the insurer shall be made to the plan sponsor or the plan itself, not the employees, members, participants, or providers.

3. The threshold for specific stop loss coverage shall be no less than $10,000 per individual participant.

4. The threshold for aggregate stop loss coverage shall be no less than 120% of expected claims.

5. The stop loss policy shall contain a provision that the plan's or the plan sponsor's bankruptcy or insolvency will not relieve the stop loss insurer from its obligation to pay claims under the stop loss policy.

6. The claim settlement period may be no less favorable than a 12/13 (incurred in 12/paid in 13).

As is obvious from reading the excerpt above, Bulletin 1993-12 regulates "stop loss" insurance. An employer who self-insures is health plan does not purchase group health insurance to insure its employees. Rather, the employer or the employer's plan pays the claims and the plan is indemnified by the employer. In other words a small employer who self-insures its health plan agrees to pay all plan benefits itself. Should a catastrophic health care problem strike one of the plan beneficiaries, that alone might be sufficient to bankrupt the employer. To protect against this risk, the employer, or the self-insured plan purchases stop loss insurance. The employer decides how much risk it can live with and purchase the appropriate amount of stop loss insurance, to cover the risk the employer does not believe it can accept. Bulletin 1993-12

sets limits on the amount of risk an employer can insure against in that it limits the amount of risks it allows stop loss carriers to cover.

Believing the Commissioner has exceeded her authority in promulgating Bulletin 1993-12, ATA sought approval of a policy which did not comply with the Bulletin. The Commissioner disapproved the proposed policy by letter dated July 6, 1995. After exhausting its administrative remedies, ATA seeks judicial review of the Commissioner's decision denying approval of the policy.

CONCLUSIONS OF LAW

In ruling on ATA's petition for judicial review, the Court must answer three questions: (1) does the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 et seq. preempt Bulletin 1993-12; (2) does the Commissioner have authority to regulate stop loss insurance; and, 3) if the Commissioner may regulate stop loss insurance, is Bulletin 1993-12 arbitrary and capricious?[1]

---

[1] Respondent states that there is also a question as to whether respondent is entitled to summary judgment. The procedural posture of this case is muddled. Petitioner filed for judicial review and subsequently filed a Motion for Judgment on the Pleadings and Certified Agency Record. In its response, respondent argued that petitioner really filed a motion for summary judgment, responded accordingly and argued that in fact it was entitled to summary judgment. Rather than getting mired in the confused posture of this case, the Court treats the briefs as arguments why the respective parties believe the law is on their side, and will determine the issues on their merits.

In deciding these questions, the Court remains cognizant of the standard of review under The Act for Judicial Review. K.S.A. 77-621 provides that the party seeking the change of an order has the burden of showing that the agency has misapplied or misinterpreted the law or that a determination of fact is "not supported by evidence that is substantial when viewed in light of the record as a whole" or is otherwise arbitrary or capricious.

"Neither the district court nor an appellate court may substitute its judgment for that of the administrative agency." *Pork Motel, Corp. v. Kansas Dept. of Health & Environment,* 234 Kan. 374 (1983). So long as the record contains competent evidence in support of the decision of the Commission, its decision is reasonable and must be upheld by this court. *Kansas Transport Co., Inc. v. State Corporation Commission,* 202 Kan. 103 (1968).

1) Does ERISA (29 U.S.C. § 1001 et seq. Preempt the Commissioner's Bulletin 1993-12?

ERISA comprehensively occupies the field of law regarding employee pension and welfare plans. An employee welfare-benefit plan or welfare plan is defined as one which provides to employees 'medical, surgical, or hospital care or benefits, . . . whether these benefits are provided 'through the purchase of insurance or otherwise.' " *Metropolitan Life Insurance Co. v. Commonwealth of Massachusetts,* 471 U.S. 724, 732 (1985) (citing 29 U.S.C. § 1002(1)).

29 U.S.C. § 1144(a) provides: "Except as provided in subsection (b) of this section, the provisions of this subchapter . . . shall supersede *any and all State laws,* insofar

as they may now or hereafter relate to any employee benefit plan. . . . " (Emphasis added.) Given the breadth of the statute's language, Bulletin 1993-12 is preempted by ERISA unless "provided in subsection (b)" of the statute. Subsection (b), known as the "savings clause" provides: "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates *insurance*, banking or securities." (Emphasis added) Predictably, the parties do not agree as to whether Bulletin 1993-12 regulates insurance. The Commissioner claims that it does; ATA claims that it regulates self-funded benefit plans rather than insurance.

To determine whether a statute regulates insurance, the Court turns to *Metropolitan Life Insurance Co. v. Commonwealth of Massachusetts*, 471 U.S. 724 (1985). There, the *Metropolitan Life* Court found that a review of case law interpreting the McCarran-Ferguson Act, 15 U.S.C. § 1011 et. seq. to be helpful. "The case law concerning the meaning of the phrase 'business of insurance' in the McCarran-Ferguson Act, 15 U.S.C. § 1011 et seq., also strongly supports the conclusion that regulation regarding the substantive terms of insurance contracts falls squarely within the saving clause as laws 'which regulate insurance.' " *Id.* at 742-743. In determining whether Bulletin 1993-12 regulates "substantive terms of insurance contracts," the Court provided a three part test: (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and, (3) whether the practice is limited to entities within the insurance industry. *Id.* at 743.

It is clear that stop loss insurance has the effect of transferring or spreading a policyholder's risk. The whole reason to purchase stop loss insurance is to spread the risk from one entirely borne by the employer to one shared by the employer and a stop loss carrier. The Bulletin directly regulates how much risk can be transferred from the employer to the carrier. The second criteria is also met by the Bulletin in that it is directed at the policy relationship between the insurer and the insured. Its reason for existence is to determine the boundaries of that relationship. Finally, the Bulletin states that the Commissioner will disapprove any policies which do not meet this requirement. Consequently, the restrictions are limited to insurance companies. Under the McCarran-Fergusan test, it is clear that the Bulletin regulates the business of insurance.

Because Bulletin 1993-12 regulates insurance, it would seem to be saved from preemption by the "savings clause." This would end the inquiry except that there is an exception to the "savings clause" called the "deemer clause." This clause states "[n]either an employee benefit plan described . . . shall be deemed to be an insurance company . . . or engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies . . . " 29 U.S.C. § 1144(b)(2)(B). In other words, a statute that "relates to" an employee benefit plan is preempted unless it regulates insurance. However, even if the statute regulates insurance, it is preempted if it relates to a self-insured benefit plan. Because, petitioner argues that Bulletin 1993-12 is actually directed at self-insured benefit plans, an analysis of the scope of preemption under the "deemer clause" is necessary.

The Fourth Circuit, in *American Medical Security, Inc. v. Bartlett*, 1997 WL 169898 (April 11, 1997) recently decided precisely this question. In fact, this case is exactly on point with that decided by the *Bartlett* Court. There, the Maryland Insurance Commissioner promulgated guidelines which required stop loss carriers to provide minimum attachment points of $10,000 for any single beneficiary and an aggregate attachment point of 115% of expected total benefit payments paid under the plan.

Maryland argued that if the state did not set these attachment points, employers, through the use of self-funded ERISA plans, could bypass the State's minimum benefit requirements. This argument is mirrored by the Commissioner here. Just as in Maryland, the Commissioner mandates that all stop loss insurance which does not meet the requirements of the bulletin is deemed to be a health insurance policy for purposes of the State's insurance regulations.

The *Bartlett* Court upheld the Maryland District Court's decision that ERISA preempted the insurance regulation. The basis of this decision was that the regulation, while "carefully drafted to focus directly on insurance companies issuing stop-loss insurance," the regulation's "purpose and effect are directed at self-funded employee benefit plans." *Bartlett* at 5. As such, the regulation "related to" an employee benefit plan. Despite the fact that the *Bartlett* case is directly on point, is the only case that this Court could find that was, and is persuasive even though it is not binding, this Court rejects the holding of the *Bartlett* Court.

In Barlett, the strongest language supporting preemption is, "[w]here the existence of ERISA plans is essential to the [state] law's operation, . . . that 'reference' will result in preemption." *Bartlett* at 4 (citing *California Div of Lab. Stds. v. Dillingham Constr.* 117 S.Ct. 832 (1997)). A review of the cases citing this phrase indicate that in practice, Courts have interpreted its language much more restrictively than the language of the phrase would indicate.

In *California Div of Lab.,* the Court rejected preemption of a state law that regulated the pay received by participants in an employee benefit plan, despite the relationship of the law to an ERISA plan. They did so because the law need not effect a covered plan, it only did so in limited cases. It should be noted that the law in question in the *California Div. of Lab.* directly mandated benefits to be paid by ERISA plans, yet was not preempted.

Mackey v. Lanier Collections Agency, 100 L.Ed.2d 836 (1988) held that a Georgia law which prohibited the garnishment of a debtor's ERISA plan benefits was preempted. This law significantly touched upon ERISA plans in that it directed a plan sponsor not to pay out monies in the plan.

Other cases where preemption was found similarly were based upon laws that directly touched plan assets or benefit levels. *Shaw v. Delta Air Lines, Inc.,* 77 L.Ed.2d 490 (1983) (holding state law which prevented discrimination in employee benefit plans on the basis of pregnancy preempted by ERISA); *Pilot Life Insurance Company v. Dedeaux,* 481 U.S. 41 (1987) (holding claims based on

improper processing of claims for benefits under ERISA plan preempted); *FMC Corporation v. Holliday,* 112 L.Ed.2d 356 (1990) (holding laws that prevented an employee benefit plan from seeking subrogation for benefits paid preempted by ERISA); *Thompson v. Talquin Building Products Company,* 928 F.2d 749 (4th Cir. 1991) (holding state law which prevented health plans from denying coverage for injuries in automobile accidents preempted as far as that law related to self-funded plans).

The Bulletin at issue in this case does not require a self-funded plan to do anything. Self-funded plans are free to purchase stop loss insurance, or not purchase it. For those employers who decide to buy it (or for those who do not), the Bulletin does not require any particular level of benefit, does not mandate what must be covered or who must be covered. The Bulletin simply tells insurance companies what type of policy if may sell in Kansas. That it may affect employer's economic decisions about the type of health plan it provides does not, without more, bring the Bulletin within the preemption tentacles of ERISA.

This conclusion finds support in recent Supreme Court decisions. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.,* 115 S.Ct. 1671 (1995) involved state laws that set surcharges on insurance purchased by benefit plans where the insurance was not purchased from Blue Cross & Blue Shield ("the Blues"). The Court found that despite the fact that the surcharge made the Blues more attractive, "an indirect economic influence, however, does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself. . . . [N]or does the

indirect influence of the surcharges preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one. It simply bears on the costs of benefits and the relative costs of competing insurance to provide them. It is an influence that can affect a plan's shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges." *New York State Conference of Blue Cross & Blue Shield Plans* at 1679. These surcharges were not preempted despite the fact that their effects were felt predominantly by ERISA plans. *See also Cal. Div. of Lab. Stds. v. Dillingham,* 136 L.Ed.2d 791, 802 (1997).

Other Courts have also permitted laws that directly impacted stop loss insurance. In *Safeco Life Insurance Co. v. Musser,* 65 F.3d 647 (7th Cir. 1995), a Wisconsin statute that charged stop loss insurance carries a tax of $239,577.93 to pay for the State's Health Insurance Risk Sharing Plan was not deemed preempted by ERISA. The fact that this cost was going to be directly passed to ERISA self-insured plans did not persuade the Seventh Circuit that the law should be preempted. In coming to its decision, the *Safeco* Court looked to *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.,* 116 S.Ct. 1671 (1995), relying particularly on the Supreme Court's statement that "[t]he basic thrust of the preemption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Safeco* at 651-52 (citing *Travelers* at 1678). There was nothing in Safeco, nor are

there any facts before this Court, indicating that regulation of stop loss insurance interferes with the "nationally uniform administration of employee benefit plans."

Although it did not have the benefit of the Supreme Court's wisdom in the *Traveler's* decision, *Safeco Life Insurance Co. v. Oregon Medical Insurance Pool,* 1992 WL 719700 (D.Or. 1992) comes to the same result. This case provides a similar factual situation to *Safeco Life Insurance Co. v. Musser,* 65 F.3d 647 (7th Cir. 1995) in that an Oregon statute taxed carriers providing stop loss insurance. The Oregon District Court held,

> Applying the deemer clause to the assessment statute in this case, I find that the Oregon statute treats self-funded plans as insureds, not insurers, and does not deem the self-funded plan as an insurer nor does it treat the plan like an insurance company. Like the tax in GM [General Motors v. California Bd. of Equalization, 815 F.2d 1305 (9th Cir. 1987], the assessment in this case is levied directly against the insurance company and as such, simply becomes part of the expense that SAFECO must pay in order to conduct business within this state.

Safeco Life Insurance Co. v. Oregon Medical Insurance Pool, 1992 WL 719700, 719701 (D.Or. 1992).

The case before this Court does not present economic effects nearly as strong as those found in *New York State Conference of Blue Cross & Blue Shield Plans.* Here, the Bulletin does not tax benefit plans either directly or indirectly. It simply provides that stop loss insurance carriers can only issue certain types of stop loss policies. Nothing in ERISA mandates that states allow employee welfare to

buy whatever they want, it only prevents states from interfering in the administration of employee benefit plans. Bulletin 1993-12 is not preempted because it does not impact the administration of an ERISA plan, but only controls what type of insurance may be purchased within Kansas.

2) **Does the Commissioner Have the Authority to Promulgate Bulletin 1993-12?**

ATA argues that there is no statutory authority within which the Commissioner may promulgate Bulletin 1993-12. The basis for this argument is that an administrative agency must regulate within the confines of its enabling statute and statutes relating to the area of law regulated by the agency. The Commissioner acknowledges that she is limited by Kansas law, but claims she has authority to regulate stop loss insurance as a result of K.S.A. 40-103, K.S.A. 40-216 and various provisions of Article 22 of Chapter 40 of the Kansas Statutes Annotated.

It is clear from the plain language of KSA 40-2201 et seq., that these statutes do no not authorize the Commissioner to regulate stop loss insurance. K.S.A. 40-2201 defines an accident and sickness policy as one that "includes any policy or contract insuring against loss resulting from sickness or bodily injury or death by accident or both . . . " A stop loss insurance contract insures the benefit plan for losses sustained by a benefit plan or an employer, not for injury or sickness. The Commissioner places great weight upon K.S.A. 40-2215(b) and K.S.A. 40-2210. Even a casual reading of these statutes

reveal they do support the Commissioner's contention that she may regulate stop loss insurance.

K.S.A. 40-2215 reads, in relevant part,

> No individual policy of accident and sickness insurance as defined in K.S.A. 40-2201 and amendments thereto shall be issued or delivered to any person in this state nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto, have been filed with the commissioner of insurance.

Again, a stop loss policy does not fall within the definition of an accident and sickness policy as defined by K.S.A. 40-2201.

K.S.A. 40-2210(A)(8) is similarly unhelpful to the Commissioner. This statute provides:

> (A)Blanket sickness and accident insurance is hereby declared to be that form of sickness and accident insurance covering special groups of persons as enumerated in one of the following paragraphs (1) to (8) inclusive.
>
> > (8) Under a policy or contract issued to any other type of group which the commissioner of insurance may find properly subject to the issuance of blanket sickness and accident policy or contract.

This argument by the Commissioner still does not get around the fact that stop loss insurance is not accident and sickness insurance as defined by K.S.A. 40-2201. Additionally, reading K.S.A. 40-2210(A)(1)-(7) indicates that these policies are sold to employers or businesses

that wish to insure against accidents that occur on their premises, or insures employees directly. Stop loss insurance does neither. Finally, a reading of K.S.A. 40-2210(B) shows clearly that the legislature did not intend to regulate stop loss insurance with this statute in that the provisions contained therein prescribe time frame within which a plan beneficiary must report their sickness or disability.

If the Commissioner has statutory authority to regulate stop loss insurance she must find it outside of K.S.A. 40-2201. In an attempt to do just that, the Commissioner points to K.S.A. 40-216 which provides in part:

> No contract of insurance or indemnity shall be issued or delivered in this state until the form of the same has been filed with the commissioner of insurance, nor if the commissioner of insurance gives written notice within thirty (30) days of such filing, to the company proposing to issue such contract, *showing wherein the form of such contract does not comply with the requirements of the laws of this state;* (Emphasis added)

ATA does not contest that the Commissioner has the power to disapprove insurance contracts which violate the laws of Kansas, they simply argue that stop loss insurance does not violate the law. K.S.A. 40-216 requires the Commissioner to show the insurer proposing a policy where the policy falls outside the laws of this State. This, so far, the Commissioner has been unable to do.

Finally, the Commissioner points to K.S.A. 40-103 to support her authority to regulate stop loss insurance. This statute is the catch all, providing the Commissioner with the power to generally makes rules "necessary to

enforce the laws of this state relating thereto." No one contests this power. However, because the Commissioner can point to no law violated by issuers of stop loss insurance whose policies fall below the criteria mandated by Bulletin 1993-12, K.S.A. 40-103 does not provide the Commissioner with power to promulgate the Bulletin.

This is supported by our Court of Appeals in *Durrett v. Bryan* 14 Kan.App.2d 723 (1990). There, an insurance company challenged an Insurance Department regulation which prohibited subrogation clauses in policies insuring persons against injuries suffered in automobile accidents. The *Durrett* Court stated:

> Administrative agencies are creatures of statute and their power is dependent upon authorizing statutes, therefore any exercise of authority claimed by the agency must come from within the statutes. There is no General or common law power that can be exercised by an administrative agency.
>
> Rules or regulations of an administrative agency, to be valid, must be within the statutory authority conferred upon the agency. Those rules or regulations that go beyond the authority authorized, which violate the statute, or are inconsistent with the statutory power of the agency have been found void. Administrative rules and regulations to be valid must be appropriate, reasonable and not inconsistent with the law.

Durrett at 727 (citing *Pork Motel, Corp. v. Kansas Dept. of Health & Environment,* 234 Kan. 374, 37-79 (1983). The *Durrett* Court then upheld the regulation only because it could find statutory authority for the regulation within K.S.A. 40-2203.

Here, there is no statutory support for the Commissioner's authority to regulate the attachment points of stop loss insurance policies. Consequently, the Court holds that the Commissioner does not have authority to issue Bulletin 1993-12. Because the Court so holds, it does not need to reach the issue of whether the limits within the Bulletin are arbitrary and capricious and declines to do so.

In conclusion, the Court finds that regulation of stop loss insurance is not preempted by ERISA because it is protected by the "savings clause" and does not fall within the "deemer clause." Insurance regulations that only remotely effect the economics of an ERISA plan are not preempted. Finally, the Court finds that the Commissioner is without authority to issue Bulletin 1993-12 because there is not statutory authority for her to regulate stop loss insurance attachment points.

JUDGMENT

For the reasons set forth above, the Court hereby grants ATA's Petition for Judicial Review and overturns the decision of the Commissioner to disapprove the stop loss policy submitted by ATA. The foregoing Memorandum Decision shall serve as the Court's entry of judgment, no further Journal Entry being required.

Dated this 25th day of April, 1997.

/s/ Terry Bullock
The Honorable
Terry L. Bullock
District Judge

STATE OF MINNESOTA
COMMISSIONER OF COMMERCE

In the Matter of the Certificate of Authority of United Wisconsin Insurance Company, a Wisconsin corporation, doing business in the State of Minnesota and the Third Party Administrator, Managing General Agent and Insurance Agency licenses of American Medical Security, Inc., a Delaware corporation doing business in the State of Minnesota.

CONSENT ORDER

TO: United Wisconsin Insurance Company, 401 West Michigan Street, Milwaukee, Wisconsin 53201 and American Medical Security, Inc., 3100 AMS Boulevard, Box 19032, Green Bay, Wisconsin 54307-9032 and their attorney, Gregory G. Scott, POPHAM, HAIK, SCHNOBRICH & KAUFMAN, LTD., Suite 3300, 222 South Ninth Street, Minneapolis, Minnesota 55402-3336.

Commissioner of Commerce James E. Ulland (hereinafter "Commissioner") has determined as follows:

1. The Commissioner has commenced formal action pursuant to Minn. Stat. §§ 45.027, subds. 6 and 7, 60A.052, 60H.07, 60H.08, subds. 1 and 2, 60K.11 and 72A.13 (1994) and § 60A.17, subds. 1(d) and 6(c) (1990) against the Certificate of Authority of United Wisconsin Insurance Company (hereinafter "Respondent UWIC"), a Wisconsin corporation, doing business in the State of Minnesota and the Third Party Administrator, Managing General Agent and Insurance Agency licenses of American Medical

Security, Inc. (hereinafter "Respondent AMS"), a Delaware corporation doing business in the State of Minnesota, based on the allegations contained in the Notice of and Order for Hearing and Order to Show Cause (hereinafter "Order to Show Cause") issued on behalf of the Commissioner by Deputy Commissioner Gary A. LaVasseur on May 15, 1995.

2. Respondents acknowledge that they have been advised of their right to a hearing in this matter, to present argument to the Commissioner, and to appeal from any adverse determination after a hearing, and Respondents hereby expressly waive those rights. Respondents further acknowledge that they have been represented by legal counsel throughout these proceedings. Respondents expressly reserve the right, in the future, to challenge the authority of the State of Minnesota and the State of Minnesota Department of Commerce to regulate the terms and conditions of self-funded welfare benefit plans and stop loss policies including Counts V, VIII, IX, X, XI and XII contained in the Order to Show Cause. This express reservation does not effect Respondents' obligation to comply with the terms of this Consent Order including the civil penalty provision and the provisions of paragraphs "A" through "F."

3. Respondents, without admitting the allegations referenced herein, have agreed to informal disposition of this matter without a hearing as provided under Minn. Stat. § 14.59 (1994) and Minn. R. 1400.5900 (1993).

4. The following Order is in the public interest.

NOW, THEREFORE, IT IS HEREBY ORDERED, pursuant to Minn. Stat. §§ 45.027, subds. 6 and 7, 60A.052,

60H.07, 60H.08, subds. 1 and 2, 60K.11 and 72A.13 (1994) and § 60A.17, subds. 1(d) and 6(c) (1990), and other applicable law, that Respondents shall pay to the State of Minnesota Department of Commerce a civil penalty of $62,500 to be remitted by Respondents upon execution of the attached Consent to Entry of Order;

IT IS FURTHER ORDERED that:

A. Respondents will send the letter attached hereto as Exhibit A (hereinafter "the letter"), to all of the Minnesota employers (hereinafter "employers") who currently have "self-funded" health insurance plans and United Wisconsin Insurance Company stop loss policies with individual attachment points below $10,000.

B. Respondents will use the following procedure with respect to mailing the letter:

1. The letter will be sent to each employer by certified mail within three weeks of the date this Consent Order is executed; and

2. Ninety days after mailing the letter, Respondents will send the Minnesota Department of Commerce (hereinafter "Department"): (a) copies of the signed, certified mail, return receipt cards; (b) a list of the employers to whom the letter was sent; and (c) an affidavit signed by a corporate officer of each Respondent stating that the letter was mailed to all of the employers referenced in paragraph "A" above.

C. After the employers receive the letter, Respondents will use the following procedure regarding contact with employers:

1. Respondents will not initiate contact with the employers for 30 days regarding the content of the letter. Respondents will also instruct their agents, in writing, not to initiate contact with the employers for 30 days regarding the content of the letter. It is acknowledged that the employers, however, are free to contact Respondents or their agents at any time following receipt of the letter;

2. Respondents will keep a log of all communications (hereinafter "Respondents' log") with employers who call Respondents within 30 days and allege that at the time of sale, they did not understand the distinction between incurred and paid claims and/or the significance of that distinction (hereinafter the "incurred/paid issue"). Respondents will also instruct their agents, in writing, to keep a log of all communications (hereinafter "agents' log") with employers who call the agents within 30 days and allege that at the time of sale, they did not understand the distinction between incurred and paid claims and/or the significance of that distinction.

3. Respondents and their agents will not contact an employer regarding the "incurred/paid issue" after receiving notice from the Department that the employer has made an allegation to the Department regarding this issue unless the Department refers the employer to Respondents or their agents.

D. If an employer makes an allegation to the Department regarding the "incurred/paid issue" within 30 days of receiving the letter, the Department and Respondents will adhere to the following procedure:

1. The Department will send Respondents a copy of any written allegation made by an employer or if there is no written allegation, a letter describing the verbal allegation;

2. Respondents will have 15 days to respond to the Department in writing;

3. The Department will consider both the allegation of the complainant and Respondents' response, and make a decision as to whether the employer's health plan, including the stop loss policy, may be required to pay claims on an incurred rather than a paid basis. In making this decision, the Department will use its experience and expertise to weigh the evidence to determine whether, at the time of sale, the complainant was mislead regarding the distinction between incurred and paid claims, and/or the significance of that distinction, due to the actions or omissions of Respondents or their agent including failure to explain the incurred/paid distinction at the time of sale. The Department will weigh: the allegations of Respondents and the complainant; the information provided by the agent who sold the Flex Funding Plan and stop loss policy to the complainant; any other written evidence; the knowledge and sophistication of the complainant pertaining to insurance and employee benefit plans; and the credibility of any witnesses contacted by the Department.

4. Based on the procedure described in paragraphs "D1," "D2" and "D3" above, the Department will decide whether to require Respondents to pay claims on an incurred basis. Respondents will abide by that decision and pay incurred claims in accordance with the

requirements of the claims settlement laws of Minnesota, Minn. Stat. ch. 72A (1994).

5. If Respondents do not respond within 15 days as provided for in paragraph "D2" above, the employer's health plan, including the stop loss policy, will pay claims on an incurred basis in accordance with the requirements of the claims settlement laws of Minnesota, Minn. Stat. ch. 72A (1994).

6. Employers who have already alleged to the Department that they did not understand the incurred/paid distinction will have their allegations handled as described in "D3" and "D4" above.

E. Within 90 days of mailing the letter, Respondents will provide the Department with a complete list of employers who chose to convert to a fully insured plan and with a copy of the Respondents' and agents' logs described in paragraph "C2" above.

F. One year after mailing the letter, Respondents will provide the Department with an accounting of claims paid on an incurred rather than a paid basis due to this Consent Order.

This Order shall be effective upon signature on behalf of the Commissioner.

Dated: 9-20-95

JAMES E. ULLAND
Commissioner of Commerce
State of Minnesota

/s/ Gary A. LaVasseur
GARY A. LaVASSEUR
Deputy Commissioner
Enforcement and Licensing
Divisions

133 East Seventh Street
Saint Paul, Minnesota 55101
Telephone: (612) 296-2594

CONSENT TO ENTRY OF ORDER

The undersigned, American Medical Security, Inc., and United Wisconsin Insurance Company, state that they have read the foregoing Consent Order; that they know and fully understand its contents and effect; that they have been advised of their right to a hearing; that they have been represented by legal counsel in this matter; and that they consent to entry of this Order by the Commissioner of Commerce. It is further expressly understood that this Order constitutes the entire settlement agreement between the parties hereto, there being no other promises or agreements, either expressed or implied.

/s/ (illegible) V.P. (illegible) Gen Couns
American Medical Security, Inc.
[SEAL]

STATE OF WISCONSIN)
) ss:
COUNTY OF Brown)

Acknowledged before me this
18day of September, 1995.

/s/ Rita A. Hurley
Notary Public

/s/ Mary Traves
United Wisconsin
Insurance Company

STATE OF WISCONSIN)
) ss:
COUNTY OF MILWAUKEE)
[SEAL]

Acknowledged before me this
9th day of September, 1995.

/s/ Lana Hertel
Notary Public

EXHIBIT A

[AMERICAN MEDICAL SECURITY LETTERHEAD]

[DATE]

Dear FlexFunding Plan Sponsor:

As a result of changes in Minnesota law and in cooperation with the Minnesota Department of Commerce, American Medical Security and United Wisconsin Insurance Company are offering you a new health-care benefits package. For the next 30 days (until October ___, 1995), you may immediately convert your FlexFunding Plan with American Medical Security and United Wisconsin Insurance Company into a conventional, fully insured group health insurance policy.

If you do not choose this option, you may continue with your current FlexFunding Plan. If you choose to keep your current plan, on your renewal date, the stop loss attachment point of your plan will increase to $10,000 as required by new Minnesota law. In addition, new Minnesota law requires that if you have 49 or fewer employees, your current FlexFunding Plan will be changed so that claims are paid on an "incurred" rather than a "paid" basis.

DIFFERENCE BETWEEN COVERAGE ON AN "INCURRED" AND "PAID" BASIS

The Fully Insured Option

The fully insured group health insurance option would operate on an "incurred" basis, rather than on a "paid" basis as your current FlexFunding Plan operates.

The difference between a "paid" basis and an "incurred" basis can be explained with the following hypotheticals:

"INCURRED" Basic Coverage

Say, for example, that your conventional, fully insured group health insurance policy is in effect for a one-year term, from January 1, 1995 through December 31, 1995. An expense is incurred on October 30, 1995, but it is not submitted to American Medical Security until December 7, 1995. American Medical Security finishes processing the claim for payment and reimbursement by January 7, 1995 [sic]. Even though the expense is not processed until after December 31, 1995, the date the insurance policy terminates, the expense nevertheless will be covered by the policy.[1] This is because the expense was "incurred" during the policy year.

FlexFunding-Coverage on a "PAID" Basis

Under your current FlexFunding Plan, however, coverage is different. Again, suppose that your FlexFunding Plan is in effect for one year, from January 1, 1995 through December 31, 1995. An expense is incurred on October 30, 1995, is submitted to American Medical Security for processing on December 7, 1995, but is not processed for payment and reimbursement until January 7, 1995 [sic]. This expense will not be covered under the FlexFunding Plan because although it was incurred during the plan year,

---

[1] This assumes that the expense would otherwise be covered under the terms of the policy.

the expense was not processed and "paid" by American Medical Security by the end of the year.[2]

THE OPTIONS AT RENEWAL

If you choose not to accept this offer to immediately convert to a fully insured group health insurance policy with American Medical Security and United Wisconsin Insurance Company, this option will again be available when it is time to renew your FlexFunding Plan.

At renewal time, you also may choose to retain the benefits of FlexFunding by designing a new FlexFunding Plan. Based upon recently enacted legislation in the State of Minnesota, this new Plan must have the following minimum features:

* a specific attachment point (i.e., your maximum claims cost per covered individual) of $10,000 or more; and

* an aggregate attachment point (i.e., the maximum amount of medical claims you could pay for your entire group in a plan year) that is lower than the sum of (i) 140% of the first $50,000 of expected plan claims, (ii) 120% of the next $450,000 of expected plan claims; and (iii) 110% of the remaining expected plan claims.

In addition, if you have 49 or fewer employees, claims will be covered on an "incurred" not a "paid" basis.

---

[2] This expense would be covered under the terms of a separate policy, however, if you purchased terminal liability insurance.

Finally, of course, you always have the option to terminate coverage with American Medical Security and United Wisconsin Insurance Company. If you terminate coverage claims that are "incurred" but not processed and "paid" as of the termination will not be covered.

If you have any questions regarding this option to immediately convert to a fully insured group health insurance policy, or if you have questions about your options at renewal, you may contact American Medical Security or the Minnesota Department of Commerce, 113 East Seventh Street, St. Paul, Minnesota 55101 (Telephone: 612/296-2488), within 30 days of receipt of this letter.

Once again, the deadline to immediately convert your FlexFunding Plan into a conventional, fully insured group health insurance policy is October ___, 1995. For more information regarding rates and terms, contact American Medical Security at 1-800-232-5432.

As always, American Medical Security and United Wisconsin Insurance Company appreciate your business.

Very truly yours,

_____

_____

_____

Supreme Court, U.S.
FILED
MAY 29 1998
CLERK

(5)

No. 97-218

In the Supreme Court of the United States

OCTOBER TERM, 1997

STEVEN B. LARSEN, MARYLAND INSURANCE COMMISSIONER, PETITIONER

v.

AMERICAN MEDICAL SECURITY, INC., ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

SETH P. WAXMAN
Solicitor General
Counsel of Record

EDWIN S. KNEEDLER
Deputy Solicitor General

EDWARD C. DUMONT
Assistant to the Solicitor General

Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

MARVIN KRISLOV
Deputy Solicitor for National Operations

ALLEN H. FELDMAN
Associate Solicitor

NATHANIEL I. SPILLER
Deputy Associate Solicitor

JUDITH D. HEIMLICH
Attorney
Department of Labor
Washington, D.C. 20210

QUESTION PRESENTED

Whether Section 514 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1144, precludes a State from specifying minimum coverage "attachment points," below which insurance policies drafted in the form of "stop-loss" or "catastrophic loss" insurance may be sold to employee benefit plans only if they comply with the State's requirements for conventional group health insurance policies.

TABLE OF CONTENTS

	Page
Opinions below	1
Jurisdiction	1
Statement	2
Discussion	9
Conclusion	20

TABLE OF AUTHORITIES

Cases:

Auer v. *Robbins*, 117 S. Ct. 905 (1997)	18
Brown v. *Granatelli*, 897 F.2d 1351 (5th Cir.), cert. denied, 498 U.S. 848 (1990)	14, 15, 16
FMC Corp. v. *Holliday*, 498 U.S. 52 (1990)	10, 12
Gonzales v. *Prudential Insurance Co.*, 901 F.2d 446 (5th Cir. 1990)	17
Lincoln Mut. Casualty Co. v. *Lectron Prods., Inc.*, 970 F.2d 206 (6th Cir. 1992)	14
Metropolitan Life Ins. Co. v. *Massachusetts*, 471 U.S. 724 (1985)	10, 12
Michigan United Food & Commercial Workers Unions v. *Baerwaldt*, 767 F.2d 308 (6th Cir. 1985), cert. denied, 474 U.S. 1059 (1986)	12, 13
Moore v. *Provident Life & Accident Ins. Co.*, 786 F.2d 922 (9th Cir. 1986)	16
Northern Group Services, Inc. v. *Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), cert. denied, 486 U.S. 1017 (1988)	13-14
Northern Group Servs., Inc. v. *State Farm Mutual Auto. Ins. Co.*, 644 F. Supp. 535 (E.D. Mich. 1986), rev'd, 833 F.2d 85 (6th Cir. 1987), cert. denied, 486 U.S. 1017 (1988)	14
Safeco Life Ins. Co. v. *Musser*, 65 F.3d 647 (7th Cir. 1995)	16-17

Cases—Continued: Page

United Food & Commercial Workers v. *Pacyga*, 801 F.2d 1157 (9th Cir. 1986) 16

Statutes and regulations:

Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.* 2
§ 3(1), 29 U.S.C. 1002(1) 2
§ 3(3), 29 U.S.C. 1002(3) 2
§ 514(a), 29 U.S.C. 1144(a) 2, 6, 7, 9
§ 514(b)(2), 29 U.S.C. 1144(b)(2) 9
§ 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A) 2, 10, 12
§ 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B) 2, 10
Colo. Rev. Stat. Ann. § 10-16-119 (West 1998) 19
Maryland Health Insurance Reform Act, Md. Ins. Code Ann. §§ 15-1201 *et seq.* (1997) 3
§ 15-1207 3
Md. Ann. Code art. 48A, §§ 698 *et seq.* (1994 & Supp. 1996) 3
Md. Regs. Code tit. 09:
§ 31.02 ..... 4, 7
§ 31.02.03(A) 5, 19
§ 31.02.03(B) 19
§ 31.03(B) 5
§§ 31.03(B)(1)-(2) 5
§§ 31.03(B)(3)-(4) 5
§ 31.05.03 3
N.J. Stat. Ann. § 17B:27A-17 (West 1996 & Supp. 1997) 19-20
N.Y. Ins. Law. § 4317(e) (McKinney Supp. 1998) 20
Or. Rev. Stat. § 742.065 (1995) 19

Miscellaneous:

1 NAIC, *Model Laws, Regulations and Guidelines* (Stop Loss Insurance Model Act 1995) 19

In the Supreme Court of the United States

OCTOBER TERM, 1997

No. 97-218

STEVEN B. LARSEN, MARYLAND INSURANCE COMMISSIONER, PETITIONER

v.

AMERICAN MEDICAL SECURITY, INC., ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is submitted in response to the Court's order inviting the Solicitor General to file a brief expressing the views of the United States.

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-15a) is reported at 111 F.3d 358. The opinion of the district court (Pet. App. 19a-34a) is reported at 915 F. Supp. 740. The district court's judgment order (Pet. App. 35a-37a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on April 11, 1997. A petition for rehearing was denied on

May 6, 1997. Pet. App. 16a-18a. The petition for a writ of certiorari was filed on August 4, 1997. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, the term "employee benefit plan" includes "any plan, fund, or program" maintained by an employer to provide "medical, surgical, or hospital care or benefits" to its participants or their beneficiaries, "through the purchase of insurance or otherwise." 29 U.S.C. 1002(1) & (3). Although ERISA generally preempts "any and all State laws insofar as they * * * relate to any employee benefit plan," 29 U.S.C. 1144(a), a saving clause provides that ERISA shall not be construed "to exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. 1144(b)(2)(A). A benefit plan itself may not, however, be "deemed to be an insurance company or other insurer * * * or to be engaged in the business of insurance" for purposes of any state law "purporting to regulate insurance companies [or] insurance contracts." 29 U.S.C. 1144(b)(2)(B).

Some employee plans purchase group insurance that provides health benefits directly to plan participants. Others pay covered health care expenses directly from the assets of the employer, or from a trust funded by employer (and sometimes employee) contributions. Even such "self-funded" plans, however, often purchase insurance to protect themselves against the possibility of unexpectedly high claims. Such "stop-loss," "excess loss," or "catastrophic loss" policies reimburse the plan for benefit

obligations in excess of certain "attachment points" —typically a "specific" attachment point, expressed as a dollar amount per participant per period, and an "aggregate" attachment point, representing a multiple (such as 110% or 115%) of the total claims expected during the period. Stop-loss insurance differs contractually from group health insurance in that the plan (or its employer sponsor) remains directly liable to participants for the payment of promised benefits, while the insurer assumes no direct liability to plan participants.

2. Petitioner regulates the insurance business in the State of Maryland. At least since the 1993 passage of the Maryland Health Insurance Reform Act, Md. Ins. Code Ann. §§ 15-1201 *et seq.* (1997), the State has required that any group health insurance policy sold to a small employer or its benefit plan must provide a number of specific benefits. Md. Ins. Code. Ann. § 15-207 (1997); Code of Maryland Regulations (COMAR) 09.31.05.03.[1] State law does not require that any employer purchase such insurance, or that any self-funded plan provide benefits equivalent to those that must be provided by an insurer.

In 1993 and 1994 (coincident with implementation of the 1993 Act), petitioner received complaints concerning the marketing of "stop-loss" policies featuring specific attachment points as low as $500 or $1000 per participant per year. Pet. App. 41a. In his order adopting the regulation at issue in this case, petitioner noted that conventional stop-loss insurance "is intended to insure only against catastrophic or un-

---

[1] The state insurance code was recodified effective October 1, 1997. The 1993 Act was previously codified at Md. Ann. Code art. 48A, §§ 698 *et seq.* (1994 & Supp. 1996).

expected losses of the policyholder/employer[,] who retains a majority of the risk of loss on himself." *Id.* at 39a. Petitioner observed, however, that a "stop-loss" policy with very low attachment points "does not insure only against catastrophic loss," but is instead "a substitut[e] for health insurance." *Id.* at 41a. In petitioner's view, insurance carriers who developed and marketed low-attachment-point "stop-loss" policies were engaged in the "subterfuge" of "categorizing an employer as self-insured, and thus exempt from the state's [mandated-benefit] laws [by reason of ERISA preemption]," while "in reality[] providing direct health insurance" that "shift[ed] the majority of the risk to the insurance carrier." *Id.* at 41a-42a. Insurers could thereby sell a product functionally equivalent to group health insurance, without providing to plan participants "the protections and benefits intended by the Maryland General Assembly" when it enacted mandated benefit legislation. *Id.* at 42a.

In light of these concerns, petitioner sought to develop a regulatory test that would "provide a reasonable basis for discriminating between health insurance and true stop loss insurance." Pet. App. 42a, 44a. After soliciting and considering public comments (see *id.* at 42a-55a), petitioner adopted Section 09.31.02 of the Code of Maryland Regulations (COMAR) (*reprinted at* Pet. App. 56a-59a) in order to "delineat[e] the difference between two types of insurance policies" by "defin[ing] the point below which the sale of 'stop loss' insurance is, in fact, [the sale of] health insurance with a deductible rather than catastrophic loss coverage." *Id.* at 50a; see also *id.* at 55a ("[t]he purpose of the regulation is to define what is true stop loss coverage"). The order dis-

claims any intention to "require an ERISA plan to provide mandated benefits, prohibit plan provisions, or force a certain benefit structure," or otherwise to "influence or regulate the underlying ERISA plan." *Id.* at 49a-50a (citations omitted).

As adopted, the regulation provides that "[a] policy or contract issued to an employer may be considered to be a policy or contract of stop-loss health insurance coverage only if" specified conditions are met. COMAR 09.31.03(B). The policy must be issued to and insure the plan (or its employer sponsor), rather than its participants or beneficiaries, and the insurer's liability on the policy must run only to the plan itself. COMAR 09.31.03(B)(1)-(2). In addition, the policy may not set a specific attachment point lower than $10,000 per participant per year, or an aggregate attachment point lower than 115% of expected total claims for the policy period. COMAR 09.31.03(B)(3)-(4). A policy that does not meet those requirements, but insures an employer against losses or claims related to employee health, "is considered to be a policy or contract of health insurance" (COMAR 09.31.02.03(A)), but it does not qualify as "stop-loss" insurance.

3. Respondents are three employer sponsors of ERISA plans, the insurance company from which they purchased a policy denominated as stop-loss insurance, and their plan administrator. Pet. App. 3a. In 1994, petitioner ordered the insurer and administrator to cease and desist from issuing or delivering unapproved insurance policies in Maryland, and to submit for approval, among other things, all policies and policy forms for stop-loss insurance issued to ERISA plans in Maryland. C.A. App. 52-57. Petitioner later informed the insurer that he would not

approve its forms without receiving written assurance that policies would not be written with attachment points less than specified minimums. Pet. App. 4a; C.A. App. 58; see Pet. App. 40a. If the insurer wished to issue a policy with lower attachment points, petitioner would "require that the contract satisfy all of Maryland's health insurance mandates." C.A. App. 58.

In this suit, respondents sought a declaratory judgment that ERISA preempts Maryland's effort to set minimum attachment points for "stop-loss" policies issued to ERISA plans.[2] Pet. App. 5a, 20a; C.A. App. 13-16. In granting summary judgment for respondents, the district court first concluded (Pet. App. 26a-28a) that the regulation "relate[s] to" ERISA plans within the meaning of ERISA's basic preemption provision, 29 U.S.C. 1144(a), because it "attempts to prevent small employers * * * from avoiding the minimum health insurance coverage required by Maryland law" by "forc[ing them] to either bear more risk by means of the adoption of a higher attachment point, or to abandon self-funding and purchase a health insurance policy which would include state-mandated coverage." Pet. App. 24a-25a.

The court further determined (Pet. App. 28a-33a) that ERISA's insurance saving clause did not apply, even though the Maryland regulation by its terms "directly regulates insurance" (Pet. App. 32a). Distinguishing between an "insured" plan, which "a

---

[2] Respondents' suit challenged the policy reflected in the cease-and-desist letters issued by petitioner, which had not yet been codified in regulations. See Pet. App. 40a. Petitioner issued a proposed regulation in 1995. See *id.* at 44a & n.2. The parties and the courts below have treated the suit as challenging the present regulation. See *id.* at 4a-5a, 20a.

State may regulate * * * indirectly through regulation of its insurer and its insurer's insurance contracts," and an "uninsured" plan, which the State "may not regulate," the court concluded that "the purchase of stop-loss insurance does not strip * * * plans of their self-funded status," and that consequently "the self-funded plans at issue in this case [could not] be considered to be insured and [therefore] subject to indirect State regulation." *Id.* at 31a-32a. Accordingly, the court held that ERISA precludes the State from "regulat[ing] the self-funded and self-insured benefit plans at issue in this case by mandating minimum attachment points for stop-loss insurance." *Id.* at 33a, 36a-37a.[3]

4. The court of appeals affirmed. Pet. App. 1a-15a. Like the district court, the court of appeals first distinguished between insured plans, which "may be indirectly regulated through regulation of th[e] insurance," and self-funded or self-insured plans, which "may not themselves be regulated * * * even if the[y] * * * purchase[] stop-loss insurance to cover losses or benefits payments beyond a specified level." *Id.* at 6a-7a.[4] The court rejected any effort to "distinguish self-funded plans from insured plans

---

[3] In a later exchange of letters with the parties, the court refused respondents' request to invalidate COMAR 09.31.02 in its entirety. See C.A. App. 117-129. The court expressly limited its judgment, enjoining enforcement of the regulation only to the extent that it mandated, regulated or affected "attachment points for stop-loss insurance policies purchased by self-funded or self-insured employee benefit plans covered by ERISA." Pet. App. 36a-37a; see C.A. App. 128-129.

[4] Petitioner conceded in the court of appeals that his regulation "relate[s] to" ERISA plans within the meaning of 29 U.S.C. 1144(a). See Pet. App. 9a-10a.

* * * based on the level of the attachment point of stop-loss insurance" (*id.* at 13a), because that would "blur[] the real distinction" between the two types of plans. *Id.* at 12a. In the court's view, that distinction was that a participant in an insured plan would have a claim for benefits directly against (and only against) the insurer, whereas a participant in a self-funded plan would have a claim only against the plan itself. *Id.* at 13a. Thus, "in a self-funded plan, with or without stop-loss insurance and regardless of the attachment point, the provision of benefits depends on the plan's solvency, whereas the provision of benefits in an insured plan depends entirely on the insurer's solvency." *Ibid.* The court accordingly considered this case on the premise that petitioner's regulation fixes minimum attachment points for "stop-loss" insurance policies issued to "self-funded" plans. *Id.* at 2a.

The court recognized that petitioner's regulation was "carefully drafted to focus directly on insurance companies issuing stop-loss insurance," and that at least "superficial[ly]" it "address[ed] the business of insurance." Pet. App. 11a. The court found the analysis "complicated," however, by its assessment that "the intended, stated, and actual effect of the regulations is to reach the relationship between ERISA plans and their participants who are not parties to the insurance contract." *Ibid.* In the court's view, petitioner had endeavored to "use stop-loss insurance policies as a vehicle to impose the requirements of Maryland health insurance law on self-funded ERISA plans," and in so doing had "crosse[d] the line of preemption" by "regulating self-funded employee benefit plans that are exclusively subject to ERISA." *Id.* at 11a-12a.

The court observed that petitioner was free to "regulate stop-loss insurance policies," because "[s]uch regulation is clearly reserved to the states." Pet. App. 15a. In this instance, however, the court concluded that the State's attempt to regulate would "directly and impermissibly affect ERISA plans' costs and choices in designing their own array of benefits," because if a self-funded plan bought stop-loss coverage with a low attachment point, "the regulation[] would either raise plan costs by including unwanted, state-mandated insurance coverage * * * or convert the self-funded plan into a fully insured plan contrary to its preference." *Id.* at 14a. Accordingly, the court held petitioner's regulation preempted, because its "purpose and effect * * * is to force state-mandated health benefits on self-funded ERISA plans when they purchase certain types of stop-loss insurance." *Id.* at 3a; see *id.* at 15a.

DISCUSSION

1. The court of appeals focused its analysis on whether the respondent plans were properly viewed as "self-funded," on the one hand, or "fully insured," on the other. See Pet. App. 12a-15a. That approach gives substantive weight to non-statutory terms that should be understood as only descriptive shorthand. ERISA's preemption and insurance saving provisions do not differentiate between benefit plans that purchase health insurance to cover their participants and those that pay covered health care expenses themselves. See 29 U.S.C. 1144(a), (b)(2). The proper statutory inquiry in this case is, instead, whether petitioner's regulation "regulates insurance" (without, for that purpose, "deem[ing]" any plan "to be an insurance company"). 29 U.S.C. 1144(b)(2).

This Court's decisions interpreting the interplay of the Act's preemption and insurance saving provisions (see 29 U.S.C. 1144(b)(2)(A) and (B)) have, to be sure, distinguished between what the Court has referred to as "insured" and "uninsured" (or "self-funded") plans. *FMC Corp.* v. *Holliday*, 498 U.S. 52, 61, 64 (1990); *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 746-747 (1985). In *FMC*, for example, the Court summarized its discussion of the statutory framework by observing that "if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it." 498 U.S. at 64. That statement may accurately capture the effect of the statutory scheme. As the Court's phrasing indicates, however, the functional distinction drawn by the Act is not between "insured" and "uninsured" plans, but rather between the regulation of benefit plans and the regulation of insurance.

A State does not acquire power to regulate a plan simply because the plan buys insurance. In buying the insurance, however, the plan must generally operate within whatever limitations or conditions a State otherwise validly imposes on the types or terms of policies that may be purchased within its jurisdiction. Thus, a State may never specify what health care benefits a plan must provide to its participants. If, however, the plan chooses to buy insurance to cover its potential liability for promised benefits, the policy options available to it in the marketplace may be validly limited by state insurance regulations—including, for example, rules that mandate the inclusion of particular benefits in any policy of health insurance. See generally *Metropolitan Life*, 471 U.S. at 739-747.

The regulation at issue in this case, as we understand it, prohibits the sale to employee benefit plans of "stop-loss" insurance that would begin covering a plan's liability for health care benefits at attachment points below state-specified minimums.[5] The court of appeals concluded that ERISA preempts the regulation because it believed that a plan that purchases insurance with benefits that run only to the plan (and not to its participants) is necessarily "self-funded," and because it regarded petitioner's regulation as an attempt to regulate such "self-funded" plans. Pet. App. 3a, 12a-14a.

It seems anomalous to characterize as "self-funded" a plan that seeks to purchase insurance to cover almost all of its potential benefits liability, and that complains only about the State's regulation of the availability or terms of such insurance. More to the

---

[5] The stated premise of the regulation—that "stop-loss" insurance with sufficiently low attachment points is functionally indistinguishable from traditional group health insurance (see, *e.g.*, Pet. App. 41a)—is a reasonable one. For many purposes, such "stop-loss" coverage closely resembles group insurance subject to a deductible, allowing the plan to bear only known or highly predictable costs, while shifting most or all risk of large or unexpected claims to the insurer. Because most employers and plan participants would perceive little or no practical difference between a group health insurance contract with a given per-employee annual deductible and a "self-insurance" plan with the same specific attachment point (provided that the two plans cover the same substantive benefits and that both employer and insurer are solvent), there is considerable force to petitioner's concern that Maryland's mandated-benefits laws will be substantially undercut if employers, unlike other consumers, may avoid the effect of those laws merely by changing the caption of their policy contracts from "group health insurance" to "stop-loss insurance."

point, however, petitioner's regulation addresses only the substantive terms on which a particular type of insurance policy may be made available by insurance companies subject to his jurisdiction—a type of regulation that this Court approved in *Metropolitan Life*. See 471 U.S. at 741. If the respondent plans do not seek to purchase that type of insurance, then they are not affected by any state regulation. If they do wish to purchase such insurance, they may do so only on the terms on which the State allows insurers to make it available.

Thus, even if petitioner intended his regulation to affect the behavior of ERISA plans, he has pursued that goal only "indirectly through regulation of [a plan's] insurer and its insurer's insurance contracts"—an approach that ERISA specifically allows. *FMC*, 498 U.S. at 64; see also *Metropolitan Life*, 471 U.S. at 731, 741-744, 747; 29 U.S.C. 1144(b)(2)(A). So long as petitioner's regulation merely limits the terms on which a particular type of insurance may be made available, and so long as enforcement of the regulation is directed solely at insurance carriers (rather than at plans or their participants), we agree with petitioner that this case is governed by the principles of *Metropolitan Life*, and that the court of appeals erred in concluding otherwise.

2. The parties appear to agree that the decision below conflicts with that of the Sixth Circuit in *Michigan United Food & Commercial Workers Unions* v. *Baerwaldt*, 767 F.2d 308 (1985), cert. denied, 474 U.S. 1059 (1986). See Pet. 16; Resp. Br. 19-20 & n.15. We perceive no clear-cut conflict in the circuits on the question presented in this case, although we agree that the reasoning of the opinion below is in

considerable tension with views expressed by at least one other court of appeals.

In *Baerwaldt*, the Sixth Circuit held that a state law mandating the inclusion of certain benefits in "all health insurance policies" could be validly applied, under *Metropolitan Life*, to "group insurance policies" purchased by two benefit plans. See 767 F.2d at 309-310 & n.1. As the court described those policies, the plans paid for all benefits "provided under the group policies up to an agreed upon amount," after which the insurer was "liable for payment of additional benefits under the applicable policies." *Id.* at 310. The opinion summarizes this arrangement by characterizing the plans as "self insured up to the claims liability limit" (*ibid.*) and the insurance as "stop loss [in] nature" (*id.* at 312).

It is at best unclear whether the contractual arrangement in *Baerwaldt* was the same as that at issue here. Nothing in the opinion specifies, for example, whether the insurer's legal duty to "pay all benefits in excess" of agreed limits (767 F.2d at 313) was owed only to the plan, or directly to plan participants. Moreover, the court's holding rests on its conclusion (*id.* at 312) that the facts before it framed "precisely" the same issue resolved by this Court in *Metropolitan Life*. It is therefore not clear either that the Fourth Circuit would have found the plans involved in *Baerwaldt* to be "self-funded" (compare Pet. App. 7a-8a, 12a-14a), or that the Sixth Circuit would consider *Baerwaldt* controlling on the facts of this case.

As petitioner points out (Pet. 16-17), the Sixth Circuit relied in part on *Baerwaldt* in deciding *Northern Group Services, Inc.* v. *Auto Owners Insurance Co.*, 833 F.2d 85, 91, 95 (1987), cert. denied, 486 U.S. 1017

(1988). Although the matter is not clear, it appears that the insurance at issue in that case may have involved a different sort of "stop-loss" arrangement. *Id.* at 91; see *Northern Group Servs., Inc.* v. *State Farm Mutual Auto. Ins. Co.*, 644 F. Supp. 535, 538 (E.D. Mich. 1986) (insurance was "obtained to insure the Plan against the employer's failure or inability to make contributions to the Trust Fund"). Moreover, the question whether one of the plans involved was "insured" was not a primary focus of the *Northern Group* opinion; and the case's primary holding—that a state coordination-of-benefits provision could be applied directly to plans that bought no insurance at all—has been superseded by this Court's decision in *FMC*. Indeed, since *FMC* the Sixth Circuit has held that application of a provision similar to that at issue in *Northern Group* was preempted, even as to a plan that purchased what appears to have been conventional "stop-loss" insurance. See *Lincoln Mut. Casualty Co.* v. *Lectron Prods., Inc.*, 970 F.2d 206, 210 & n.3 (1992). We are therefore reluctant to place great weight, for present purposes, on *Northern Group*'s passing reference to *Baerwaldt*.

There is some tension between the decision below and considered dicta in the Fifth Circuit's decision in *Brown* v. *Granatelli*, 897 F.2d 1351, cert. denied, 498 U.S. 848 (1990). *Brown* held that a Texas mandated-benefits law did not, as a matter of state law, apply to the particular stop-loss health benefits policy at issue in that case—thus avoiding any ERISA preemption issue. *Id.* at 1354; see *id.* at 1355 (Reavley, J., concurring). The court emphasized, however, that its state-law holding should not be extended to other facts in a way that would "frustrate an otherwise manifest [state] legislative purpose":

> We do not suggest that [the mandated benefits law] can be avoided by naming an employee benefit plan as the insured on a policy which in reality insures the plan participants. If, for example, a plan paid only the first $500 of a beneficia[ry's] health claim, leaving all else to the insurer, labeling its coverage stop-loss or catastrophic coverage would not mask the reality that it is close to a simple purchase of group accident and sickness coverage. We look beyond form to the substance of the relationship between the plan, the participants, and the insurance carrier to see whether the plan is in fact purchasing insurance for itself and not for the plan participants, recognizing that as insurance is less for catastrophic loss, it is increasingly like accident and sickness insurance for plan participants. * * * In short, if the Plan were merely a conduit for claims from participants to [the insurer] we could not reach the same conclusion.

Id. at 1355; see also *id.* at 1356 (Brown, J., dissenting).

These observations bear a striking resemblance to petitioner's stated rationale for adopting the state regulation at issue in this case. Compare Pet. App. 40a-47a, 50a; see note 5, *supra*. While not essential to the court's decision in *Brown*, they were plainly included in its opinion in order to clarify and confine the holding of the case. See 897 F.2d at 1354 (holding subject to an "important qualification"). And, while the court did not reach the issue of ERISA preemption, the thrust of the opinion suggests that if the panel had felt it appropriate to recharacterize a nominal "stop-loss" policy as "group accident and

sickness coverage" for purposes of state law, it would have been inclined to view that law as regulating "insurance" and therefore as saved from preemption. See also *id.* at 1358 (Brown, J., dissenting) (plan participants should be able to enforce state benefit mandates directly against a stop-loss carrier no matter what the policy's attachment point).

One might therefore infer that the Fifth Circuit would likely uphold, against an ERISA preemption challenge, a state regulation that sought, as a matter of state insurance law, to "define[] the point below which the sale of 'stop-loss' insurance is, in fact, health insurance with a deductible rather than catastrophic loss coverage." Pet. App. 50a. On the other hand, one might also infer that it would likely sustain an ERISA preemption challenge if it thought that state regulators had purposely set the attachment point too high in an attempt to impose mandated benefits on self-funded plans. The fact remains, therefore, that neither the Fifth Circuit nor any other federal court of appeals has, to our knowledge, squarely addressed a situation directly comparable to that at issue here and resolved an actual case in a manner that conflicts with the decision below.[6]

---

[6] Petitioner suggests (Pet. 18) a conflict with *United Food & Commercial Workers* v. *Pacyga*, 801 F.2d 1157, 1161 (9th Cir. 1986), and *Moore* v. *Provident Life & Accident Insurance Co.*, 786 F.2d 922, 927 (9th Cir. 1986), but those cases hold only that an ERISA plan does not, by virtue of purchasing stop-loss insurance, become subject to state anti-subrogation rules or to state causes of action that would lie against an insurer—an issue quite different from whether a State may reasonably define when a policy denominated "stop-loss" insurance will be treated as a group health insurance policy for state regulatory purposes. Nor does the decision below conflict with *Safeco Life*

3. The parties to this case, joined by 22 States, the District of Columbia, and the National Association of Insurance Commissioners, contend that the question presented here is one of current importance and wide application that should be resolved promptly. We have no reason to dispute that contention. Two factors, however, give us pause in suggesting that this case meets the Court's usual prudential standards for granting discretionary review. The first is the absence, as just discussed, of any actual conflict among the lower courts on the precise question presented. The second is a possible ambiguity in the Fourth Circuit's treatment of the particular state regulation at issue in this case.

We have discussed this case on the premise that petitioner's regulation simply prohibits the sale to employee benefit plans of "stop-loss" coverage that attaches at per-person or overall liability limits lower than state-specified minimums—with the consequence that employers or plans that do not wish to assume the specified level of potential direct liability have only one insurance option, which is the purchase of conventional group health insurance that is subject to state mandatory benefit laws. See page 11, *supra*. We understand that to be petitioner's interpretation of his own rule (see Pet. 4-5, 14-15; Pet. C.A. Br. 12-13, 20-25; Pet. C.A. Rep. Br. 6, 8-9); nothing in respondents' brief in this Court is inconsistent with that

---

Insurance Co. v. *Musser*, 65 F.3d 647, 651 (7th Cir. 1995) (fee imposed on all health insurers in a State does not "relate to" ERISA plans), or with *Gonzales* v. *Prudential Insurance Co.*, 901 F.2d 446, 452-454 (5th Cir. 1990) (state disability insurance laws may not be applied directly to an ERISA plan). See Minnesota *et al.* Amicus Br. 11; Nat'l Ass'n of Ins. Comm'rs Amicus Br. 14-15.

position (see Resp. Br. 1, 8-10, 16); and the district court's judgment, which the court of appeals affirmed without modification (Pet. App. 15a), was limited to the preemption of "any regulation * * * that mandates or affects attachment points for stop-loss insurance policies purchased by self-funded or self-insured employee benefit plans" (*id.* at 36a; see note 3, *supra*).[7] The Court could appropriately accept and decide the case on the same assumption. Cf. *Auer* v. *Robbins*, 117 S. Ct. 905, 911 (1997) (agency's interpretation of its own regulations is normally "controlling").

We note, however, that respondents' brief in the court of appeals at times suggested that petitioner's regulation goes further, by "recharacterizing stop-loss reinsurance as health insurance" in a way that "fundamentally alter[s] the benefit structure established by any plan that runs afoul of [the regulation's] provisions" and "*creat[ing]* a relationship between the stop-loss reinsurer and the beneficiaries of the plan." Resp. C.A. Br. 34; see also *id.* at 38-40 (discussing other provisions of the regulation, and arguing that the district court erred in not declaring them preempted). More important, it is difficult to tell from the opinion below whether the court of appeals read the regulation simply to prohibit sales of stop-loss insurance with attachment points below the mandatory minimums (so that only group health insurance, subject to the State's mandatory benefit provisions, may be made available for purchase), or

---

[7] The only enforcement action that petitioner took in this case was to disapprove respondents' purported stop-loss policies and order that they not be sold in Maryland. C.A. App. 52-59; Pet. 15; Pet. App. 4a.

whether it believed that the regulation would have the effect of recharacterizing existing policies with low attachment points as health insurance policies (thereby creating liability for additional benefits on the part of a plan or its insurer by operation of law). See Pet. App. 3a, 5a, 9a, 14a-15a.

While we understand petitioner to disavow any intention to convert policies issued as "stop-loss" coverage into group health policies by operation of state law, and although petitioner's permissible interpretation of his own regulation should be dispositive on that point, the regulation's text could, on its face, support either construction. See COMAR 09.31.02.03(A) and (B) (defining any policy that insures against employee health-related "losses or claims" as "health insurance" and establishing requirements for "stop-loss health insurance coverage," but not defining the consequences of either designation). A state regulation that purported to rearrange existing contractual relationships among plans, their participants, and plan insurers, even as a remedy for violation of an otherwise valid insurance regulation, would raise concerns substantially different from those discussed above, and might well be preempted by ERISA. The operative interpretation of state law could therefore be of critical importance in resolving this case.[8] The state-law question is not,

---

[8] The Stop Loss Insurance Model Act promulgated by the National Association of Insurance Commissioners is substantially clearer in this regard than petitioner's regulation. See 1 NAIC, *Model Laws, Regulations and Guidelines* 92-1 (1995). It appears that a number of other States have also taken some legislative or regulatory action on the "stop-loss" issue. See, *e.g.*, Or. Rev. Stat. § 742.065 (1995); Colo. Rev. Stat. Ann. § 10-16-119 (West 1998); N.J. Stat. Ann. § 17B:27A-17 (West 1996 & Supp.

however, well developed on the present record, and at any rate it would not in itself warrant review by this Court.

Although the question is a close one, on balance we believe that the potential ambiguity in applicable state law and the absence of a square conflict in the circuits counsel against the use of this case as a vehicle for review of the question presented.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

SETH P. WAXMAN
Solicitor General

EDWIN S. KNEEDLER
Deputy Solicitor General

EDWARD C. DUMONT
Assistant to the Solicitor General

MARVIN KRISLOV
Deputy Solicitor for National Operations

ALLEN H. FELDMAN
Associate Solicitor

NATHANIEL I. SPILLER
Deputy Associate Solicitor

JUDITH D. HEIMLICH
Attorney
Department of Labor

MAY 1998

1997) (*s.v.* "stop loss"); N.Y. Ins. Law § 4317(e) (McKinney Supp. 1998).

(6)

Supreme Court, U.
FILED
JUN 12 1998
CLERK

No. 97-218

In The

Supreme Court of the United States

October Term, 1997

STEVEN B. LARSEN, in his capacity as Insurance Commisssioner of the State of Maryland,

Petitioner,

vs.

AMERICAN MEDICAL SECURITY, INC., *et al.*,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

SUPPLEMENTAL BRIEF FOR RESPONDENTS

ANDREW JAY GRAHAM
KATHLEEN A. BIRRANE
KRAMON & GRAHAM, P.A.
One South Street
Suite 2600
Baltimore, Maryland 21202
(410) 752-6030

EDWARD J. BIRRANE, JR.
Counsel of Record
CYNTHIA M. DIETZ
EDWARD J. BIRRANE, JR. Chartered
28 West Allegheny Avenue
Suite 606
Towson, Maryland 21204
(410) 823-0464

Attorneys for Respondents

146857

(800) 274-3321 • (800) 359-6859
A DIVISION OF COUNSEL PRESS

Lutz Appellate Services, inc.

20 pp

TABLE OF CONTENTS

		Page
I.	This Court Should Issue Its Writ To Clarify And Stabilize A Crucial Area Of Erisa Law.	1
II.	Developing Mechanisms To Eliminate Self-funded ERISA Plans Is Not The Regulation Of The Business Of Insurance.	2
III.	The Maryland Regulation Unambiguously Converts Stop Loss Insurance Into Group Health Insurance.	7
Conclusion		10

TABLE OF CITATIONS

Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724, 743 (1985) 3, 10

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers, Inc., 514 U.S. 645 (1995) 10

Travelers Ins. Co. v. Cuomo, 14 F.3d 708 (2nd Cir. 1993), *rev'd on other grounds*, 514 U.S. 645 (1994) 2

Statutes Cited:

29 U.S.C. § 1144(b)(2)(A) 3

29 U.S.C. § 1144(b)(6)(A)(ii) 5

Contents

	Page
29 U.S.C. § 1144(b)(6)(D)	5
Md. Code Ann., Insurance Art. § 12-103	9

APPENDIX

Appendix A — Statutes Involved	1a

This case presents the question of whether a state regulation that is intended to prevent small employers from forming self-funded employee welfare benefit plans is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"). In their Brief in Opposition, Respondents demonstrated that the preemption issues presented by this case are of great public importance and that this Court should issue its Writ in order to affirm the holding of the United States Court of Appeals for the Fourth Circuit.

On May 29, 1998, in response to this Court's invitation, the United States filed its Brief for the United States as *Amicus Curiae*. Although the United States concludes that the court of appeals may have erred, it cautions against review. First, the United States suggests that there is merely a tension, and not an actual conflict, among the circuits on the issues presented by this case. Second, the United States contends that there is a state law question regarding the operation of the state regulation that bears on the preemption issue, but which was not sufficiently developed below. Because the views articulated by the United States are premised on certain fundamental inaccuracies, Respondents submit this Supplemental Brief.

I.

THIS COURT SHOULD ISSUE ITS WRIT TO CLARIFY AND STABILIZE A CRUCIAL AREA OF ERISA LAW.

Respondents do not disagree with the United States' analysis of the tension that exists among the circuits with respect to the issues raised by this case. Respondents disagree, however, that that militates against this Court's review of those issues. While there may be only tension among the circuits, there is clear conflict between the states and the circuits. At the time that the Petition was filed, 16 states in addition to Maryland regulated attachment points for stop loss insurance polices issued to employee welfare benefit

plans. The minimum attachment points set by those states vary from the Maryland regulation and from one another.[1]

This conflict in the actual regulation of attachment points has led to confusion in an industry that affects millions of employees. That confusion must be resolved by this Court. If self-funded plans cannot cede what they deem to be excess risk without being forced to adopt the benefit structure decreed by the state, self-funding will no longer be a viable option for many employers.

II.

DEVELOPING MECHANISMS TO ELIMINATE SELF-FUNDED ERISA PLANS IS NOT THE REGULATION OF THE BUSINESS OF INSURANCE.

The United States identifies the critical statutory inquiry in this case as "whether petitioner's regulation 'regulates insurance (without, for that purpose, 'deem[ing]' any plan 'to be an insurance company')." Brief for United States at 9. Although it answers that inquiry in the affirmative, the United States fails to articulate the factors to be considered in assessing whether state action is the regulation of insurance and ignores the court of appeals' articulation and application of those factors.

The United States' position is wrong, because it ignores the fact that the express goal of petitioner's regulation is to eliminate

---

1. In *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708 (2nd Cir. 1993), *rev'd on other grounds*, 514 U.S. 645 (1994), the Second Circuit concluded that ERISA preempted an actuarial letter issued by the New York Department of Insurance that purported to regulate the terms of stop loss insurance contracts, because the regulation required the stop loss carrier to, among other things, include certain mandated coverages. The Second Circuit found that such a regulation was merely a pretext to regulate the terms of self-funded ERISA plans and, therefore, was not saved as the regulation of insurance. *Id.* at 724. This Court declined consideration of that holding in that case. This case (and the patchwork of state legislation in this area) demonstrates, however, that the question is a reoccurring one that both requires and merits this Court's consideration.

self-funding by certain employers by forcing the plan to accept more risk than prudent management would dictate. As the court of appeals correctly concluded, the elimination of self-funded benefit plans is not the regulation of insurance, regardless of the mechanism employed to accomplish it and, thus, the regulation is not saved.

The savings clause preserves from preemption any state law "which regulates insurance, banking or securities." 29 U.S.C. § 1144(b)(2)(A). In determining whether a state law is saved by the savings clause, this Court has adopted a conjunctive, two-step approach. First, the regulation must fall within the "common sense" definition of insurance. *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 740-41 (1985). Second, the regulation must meet the three prong test adopted in interpreting the McCarran-Ferguson Act. *Id.* at 743.[2]

The court of appeals correctly concluded that the Maryland regulation is not the regulation of insurance, because it merely uses the regulation of "stop loss insurance policies as a vehicle to impose the requirements of Maryland health insurance law on self-funded ERISA plans." Pet. App. 12a. As Judge Niemeyer reasoned:

> In this case, the Maryland Insurance Comissioner can well argue with respect to the first *Metropolitan Life* factor that the setting of attachment points allocates

---

2. As Judge Niemeyer stated:

> In determining whether a state law is one that "regulates insurance" it is not enough that it operate only on insurance companies or insurance policies. The regulation must regulate the business of insurance in the sense that the object of its regulation (1) "has the effect of transferring or spreading a policyholder's risk"; (2) "is an integral part of the policy relationship between the insurer and the insured"; and (3) "is limited to entities within the insurance industry."

Pet. App. 10a (quoting *Metropolitan Life*, 471 U.S. at 743).

plans. The minimum attachment points set by those states vary from the Maryland regulation and from one another.[1]

This conflict in the actual regulation of attachment points has led to confusion in an industry that affects millions of employees. That confusion must be resolved by this Court. If self-funded plans cannot cede what they deem to be excess risk without being forced to adopt the benefit structure decreed by the state, self-funding will no longer be a viable option for many employers.

II.

DEVELOPING MECHANISMS TO ELIMINATE SELF-FUNDED ERISA PLANS IS NOT THE REGULATION OF THE BUSINESS OF INSURANCE.

The United States identifies the critical statutory inquiry in this case as "whether petitioner's regulation 'regulates insurance (without, for that purpose, 'deem[ing]' any plan 'to be an insurance company')." Brief for United States at 9. Although it answers that inquiry in the affirmative, the United States fails to articulate the factors to be considered in assessing whether state action is the regulation of insurance and ignores the court of appeals' articulation and application of those factors.

The United States' position is wrong, because it ignores the fact that the express goal of petitioner's regulation is to eliminate

---

1. In *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708 (2nd Cir. 1993), *rev'd on other grounds*, 514 U.S. 645 (1994), the Second Circuit concluded that ERISA preempted an actuarial letter issued by the New York Department of Insurance that purported to regulate the terms of stop loss insurance contracts, because the regulation required the stop loss carrier to, among other things, include certain mandated coverages. The Second Circuit found that such a regulation was merely a pretext to regulate the terms of self-funded ERISA plans and, therefore, was not saved as the regulation of insurance. *Id.* at 724. This Court declined consideration of that holding in that case. This case (and the patchwork of state legislation in this area) demonstrates, however, that the question is a reoccurring one that both requires and merits this Court's consideration.

> insurance and its coverage of risks, but with the benefits that ERISA plans can choose to provide their participants and beneficiaries. No matter how understandable this concern may be, only Congress may address it, not the State of Maryland through its insurance regulations.

Pet. App. 12a.

The United States also accepts the fundamentally erroneous proposition that stop loss insurance with low attachment points is the equivalent of group health insurance and that benefit plans that purchase stop loss insurance are not truly self-funded. This is particularly disturbing given that the Department of Labor ("DOL"), in its advisory opinions, has consistently taken the position that a contract of stop loss insurance is not group health insurance and that ceding even 100% of the risk does not necessarily convert a self-funded benefit plan into a fully insured plan.

Pursuant to amendments adopted by Congress in 1983, an employee welfare benefit plan that is a multiple employer welfare arrangement ("MEWA") may be regulated by the states. If the MEWA is fully insured, there is no limitation as to the scope of the state's regulatory authority. If, however, the MEWA is not fully insured, the state regulation is limited to state laws that are not inconsistent with ERISA. 29 U.S.C. § 1144(b)(6)(A)(ii).

A MEWA is considered to be fully insured only if "all" of the benefits provided "are guaranteed under a contract, or policy of insurance . . ." 29 U.S.C. § 1144(b)(6)(D). DOL has consistently taken the position that "[t]he fact that [a MEWA] may have obtained stop loss insurance does not in itself indicate that the Trust is fully insured within the meaning of [29 U.S.C. § 1144(b)(6)(D)]." ERISA Advisory Opinion 90-48A; *see also* ERISA Advisory Opinion 91-05A.[3] A stop loss insurance policy is only considered

3. All advisory opinions referred to herein have been lodged with the Court.

to be fully insured "if the terms of the arrangement provide that the amount of *all* benefits are guaranteed under the insurance contract or policy." ERISA Advisory Opinion 91-05A (emphasis added).

In response to an inquiry from the Commissioner of Insurance for the State of Connecticut, the Director of Regulations and Interpretations at the Pension and Welfare Benefit Administration of DOL issued an advisory opinion on whether a MEWA that intended to cede or secure guarantees covering 100% of its assumed risk was fully insured. ERISA Advisory Opinion 94-07A. A non-profit trade association of small employers consolidated seven trusts into a single Trust, which received contributions from participating employers and paid claims to employee beneficiaries. The Trust entered into a " 'quota share reinsurance agreement' " with National Health Insurance Company ("NHIC") through which NHIC agreed to "pay to the Trust 90% of the liabilities that the Trust incurs under its benefit plan, up to a per-claim limit of $10 million" and to "guarantee[ ] payment to the Trust of the Trust's retained portion of the liabilities in the event the Trust is unable to fund that portion." *Id.* at 5. DOL found that the agreement between NHIC and the Trust would not cause the Trust to be fully insured, primarily because plan participants would "be required to present benefit claims to the Trust, and benefit payments would be made solely by or on behalf of the Trust." *Id.* at 6.

This is precisely the reasoning employed by the court of appeals in rejecting petitioner's suggestion that stop loss insurance is the functional equivalent of group health insurance. The court noted that

> Under a self-funded plan, the employer who promises the benefit incurs the liability defined by the plan's terms. That liability remains the employer's even if the stop loss insurer becomes insolvent. Conversely, if the employer becomes insolvent, the solvency of the stop loss insurer may not benefit plan participants

> and beneficiaries * * * . In contrast, when a plan buys health insurance for participants and beneficiaries, the plan participants and beneficiaries have a legal claim directly against the insurance company, thereby securing the benefits in the event of the plan's solvency * * * .

Pet. App. 13a.

In short, as the court of appeals correctly recognized, a state regulation which is promulgated for the express purpose of forcing certain self-funded plans to abandon self-funding does not regulate insurance and is not saved from preemption. The Brief of the United States as *Amicus Curiae* ignores this fundamental point and, thus, adopts a position that is fundamentally wrong.

III.

THE MARYLAND REGULATION UNAMBIGUOUSLY CONVERTS STOP LOSS INSURANCE INTO GROUP HEALTH INSURANCE.

The United States concedes that a

> regulation that purported to rearrange existing contractual relationships among plans, their participants, and plan insurers, even as a remedy for violation of an otherwise valid insurance regulation * * * might well be preempted by ERISA.

Brief of the United States at 19. That is precisely what the Maryland regulation does. Nonetheless, the United States contends that this case is not an appropriate vehicle to address this issue, because, it claims: (a) petitioner has disavowed "any intention to convert policies issued as 'stop loss' coverage into group health policies by operation of state law . . . ."; (b) the United States perceives an ambiguity as to whether the regulation would effectively convert

PUBLISHER'S NOTE:

THE FOLLOWING PAGE WAS UNAVAILABLE FOR FILMING:

8

The regulation clearly intends to treat as group health insurance stop loss policies that are issued with attachment points below the stated minimum. There can be no good faith argument that the consequence of labeling a stop loss policy a group health policy is anything other than to require an employer to provide mandated benefits. The Maryland Insurance Code states:

> An otherwise valid insurance policy, rider, or endorsement issued after December 31, 1963, with a condition or provision that does not comply with the requirements of this article is not invalid but is to be construed and applied in accordance with the condition or provision that would be applicable if the policy, rider, or endorsement were in full compliance with this article.

Md. Code Ann., Ins. Art. § 12-103.

Notwithstanding whatever private disavowals petitioner may have made to the United States, the regulation, on its face, clearly and unambiguously converts into group health insurance any stop loss policy that does not meet the statutory criteria. That aspect of the regulation's operation was one of the bases on which the court of appeals concluded that the regulation was preempted and there is no impediment to this Court's consideration of the regulation or its operation.

CONCLUSION

This case squarely presents questions left open by *Metropolitan Life* and its progeny and is the perfect vehicle by which to clarify that state action that intentionally or effectively forces an employee benefit plan to adopt a particular benefit structure or to terminate is preempted by ERISA.[4] For the reasons set forth herein, and in Respondents' Brief in Opposition, this Court should grant the Petition.

Respectfully submitted,

EDWARD J. BIRRANE, JR.
Counsel of Record
CYNTHIA M. DIETZ
EDWARD J. BIRRANE, JR. Chartered
28 West Allegheny Avenue
Suite 606
Towson, Maryland 21204
(410) 823-0464

ANDREW JAY GRAHAM
KATHLEEN A. BIRRANE
KRAMON & GRAHAM, P.A.
One South Street
Suite 2600
Baltimore, Maryland 21202
(410) 752-6030

---

4. This is precisely the issue that Mr. Justice Souter seemed to invite, albeit at a different point in the ERISA preemption analysis, when he noted in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers, Inc.*, 514 U.S. 645, 668 (1995):

> We acknowledge that a state law might produce such acute, albeit indirect economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be preempted under § 514.

APPENDIX

APPENDIX A — STATUTES INVOLVED

29 U.S.C. § 1144

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies,

insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section —

(i) any state tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii

to assist them in effectuating the policies of provisions of such Act which are superseded by such parts.

(6)(A) Notwithstanding any other provision of this section —

> **(i)** in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides —
>
> > **(I)** standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and
> >
> > **(II)** provisions to enforce such standards, and
>
> **(ii)** in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted

insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section —

(i) any state tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii

State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

Appendix A

ANNOTATED CODE OF MARYLAND, INSURANCE ARTICLE § 12-103

§ 12-103. Validity and construction of noncomplying conditions or provisions.

An otherwise valid insurance policy, rider, or endorsement issued after December 31, 1963, with a condition or provision that does not comply with the requirements of this article is not invalid but is to be construed and applied in accordance with the condition or provision that would be applicable if the policy, rider, or endorsement were in full compliance with this article. (An. Code 1957, art. 48A, § 378; 1995, ch. 36.)